

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 06/02/2026
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 0689 Level of Harm - 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, observation, and record review, the facility failed to maintain resident safety by failing to implement fall interventions and performing safe transfers. for 4 of 6 residents (R4, R5, R13, R500) reviewed for resident safety in the sample of 31. This failure resulted in R4 being hospitalized for fractures resulting in surgery and R500 being hospitalized for subdural hematoma, and spinal fractures. The findings include: 1. R4's admission Record, dated 5/28/26, documents R4 was admitted to the facility on [DATE].R4's Medical Diagnosis include on 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.R4's Care Plan, dated 5/23/26, documents At risk for falls and injuries r/t (related to) Medications: Psychotropic meds/Diuretic meds/Cardiovascular Meds/Pain Meds. Medical Factors: History of Falls. Interventions: 4/9/2026: Mat to bedside, 5/12/26: non-slip pad to wheelchair, 4/6/26: Bed in lowest position, encourage call light usage, ensure proper footwear when ambulating, provide/reinforce the importance of sitting on side of bed prior to standing, provide/reinforce use of assistive devices: (Specify: Reacher, Walker, Cane, Wheelchair, Transfer Pole, etc.), scoop mattress. It continues R4 Needs assistance with activities of daily living (ADLs). Interventions: Toilet Use: Two-person physical assist required, Transfer: Mechanical lift required. sit to stand with belt around Lower Extremities. R4's Minimum Data Set (MDS), dated [DATE], documents R4 has a moderate cognitive impairment and is dependent on staff for all ADLs and transfers. R4 is always incontinent of both bowel and bladder.R4's admission Fall Risk Assessment, dated 4/6/26, documents R4 was a High Fall Risk.The facility's fall log for the last six months, documents R4 had falls on 4/9/26 and 5/12/26.On 5/26/26 at 9:40 AM, R4 was seen sitting in his wheelchair, call light on self, R4 has thoracic brace on his bed, no fall mat seen anywhere in the room, no non-slip pad seen in his wheelchair, and no scoop mattress on the bed.On 5/26/26 at 9:56 AM, V9, Certified Nursing Assistant (CNA), and V6, CNA, walked into R4's room to transfer him to his bed and perform peri-care. The full body mechanical live device sling was already under R4 while in his wheelchair. R4 was attached to the lift device and with the wheelchair unlocked, lifted R4 off his wheelchair, then moved to his bed and lowered. There was no non-slip pad seen on his wheelchair after lifting R4 off, there was no scoop mattress on his bed, and there was no mat on the floor or in the room.On 5/27/26 at 8:17 AM, R4 was sitting in his wheelchair next to his bed which had a regular mattress and no scoop mattress, there was no fall mat on the floor or seen anywhere in the room.On 5/27/26 at 2:06 PM, R4 was seen lying in bed with a regular mattress and no scoop mattress, and with no fall mat seen on the floor, around his bed, or anywhere in the room.On 5/28/26 at 11:00 AM, R4 was seen lying in bed asleep with a regular mattress and no scoop mattress and with no fall mat next to his bed. Upon examination of R4's wheelchair, there was no non-slip pad seen in his wheelchair, either on top of cushion or underneath cushion.R4's Health Status Note, dated 4/9/26 at 1:44 AM, documents Resident moaning, staff member went to check on res (resident) and he was (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
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F 0689 Level of Harm - Actual harm Residents Affected - Few	laying on floor between wall and bed, next to air conditioning unit. S/T (skin tear) noted to left arm, bleeding noted to left arm and right great toe. Resident is on Eliquis. C/O (complaint of) back pain, call placed to 911 for transfer. MD (medical doctor) notified, pressure dressing applied to left arm. POA (power of attorney) HC (healthcare) notified and would like a call back with update if he returns from hospital. Call place to (local hospital) and report given to ER (emergency room) Nurse. Neuro checks initiated.R4's F/U (follow-up) Occurrence Note, dated 4/9/26 at 2:03 AM, documents Incident Note: Resident moaning, staff member went to check on res and he was laying on floor between wall and bed, next to air conditioning unit. S/T noted to left arm, bleeding noted to left arm and right great toe. Resident is on Eliquis. C/O back pain, Call placed to 911 for transfer.R4's Health Status Note, dated 4/9/26 at 5:30 AM, documents Received call from (local hospital) ER, resident is being transferred to (regional hospital) with diagnosis of L1-L4 fractures. Niece notified of transfer by (local hospital) ER Nurse. Manager on call notified of incident with injury and transfer.R4's Health Status Note, dated 4/9/26 at 10:49 AM, documents This writer called and spoke with ED (emergency department) nurse at (regional hospital). Resident is still in ED at this time and will be admitted with right femur fx (fracture). Resident had fx upon admission to facility per paperwork no ortho interventions were in place at time of admission. Will cont (continue) to follow for updates.R4's Health Status Note, dated 4/10/26 at 11:58 AM, documents This writer spoke with NP (Nurse Practitioner) at (regional hospital). Resident and family decided to pursuit surgical tx (treatment) to previous femoral fx. per NP surgery is today. Will continue to follow up with (regional hospital) for updates.R4's Fall Investigation, dated 4/15/26, documents Brief description of incident: Resident had fall from bed and sent to local hospital with pre-existing hip fx. Resident was sent to (regional hospital) for further evaluation. Immediate Action Taken: Resident was immediately assessed and sent out for further evaluation for fall from bed. Resident room was moved to higher traffic area. Summary of Investigative findings: On 4/9/26, resident experienced a fall at the facility. The fall was unwitnessed and occurred in resident's room. Immediate assessment was completed, and the resident was transferred to the local emergency room for further evaluation. The emergency room initially reported a new fracture. Upon further diagnostic review and comparison with prior medical records, the fracture was determined to be pre-existing and consistent with a previous injury sustained prior to admission, from a fall at home. No evidence supports that the fracture resulted from the current incident. Resident assessed immediately post-fall with no acute distress noted beyond baseline. Transferred to ER for evaluation and imaging. Notifications completed: MD, responsible party, and all required entities per protocol. Care plan reviewed and updated as appropriate to address fall risk. The alleged injury (fracture) was not caused by the facility fall and is determined to be pre-existing. Therefore, the allegation is unsubstantiated. The Follow-up actions taken after the fall: Interviewed staff regarding resident incident, a fall mat was put in place at the bedside, and R4's room was moved to a higher traffic area on return.R4's fall on 4/9/26, documents R4 was found after falling out of his bed. R4 did not have the the fall intervention of a scoop mattress in place, helping to prevent R4 from falling out of bed. The fall mat in place was added to the Care Plan after R4's fall on 4/9/26. R4's Emergency Department Record, dated 4/9/26, documents in part History of present illness: Patient arrived from the nursing home after reportedly falling form bed onto floor. Emergency Course: He has known fx R (right) femur that is being tx conservatively/non-operative. CT (cat scan) L (left)-Spine: Fx L transverse process L1, L2, L3, and R transverse process L4. XR (x-ray) R femur: Hip prosthesis, fx lesser trochanter. (regional hospital) transfer - send pt (patient) to ED for trauma evaluation: fall, hypotension, tachycardic, multiple transverse process fx L1-L4. Clinical Diagnosis: Accidental fall, Closed fracture of transverse process of lumbar vertebra, Femur fracture, right. CT lumbar spine without contrast: Impression: Multiple acute fractures of the lumbar transverse process. L1 through L4. Comparison right hip and pelvis radiographs 4/5/26, Impression: Orthopedic components of a right hip hemiarthroplasty with cerclage wire about the proximal femoral stem with redemonstration of an obliquely oriented periprosthetic fracture along the medial aspect of the femoral stem with increased (continued on next page)		

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F 0689 Level of Harm - Actual harm Residents Affected - Few	displacement compared to the prior examination.R4's Fall Investigation, dated 5/12/26, documents Nursing description: Staff walking past res room and seen res sliding out of w/c (wheelchair) onto floor, res sitting on buttocks, urinal inside res pants, able to [NAME] (moves all extremities) WNL (within normal limits) for res, without pain or discomfort, used mechanical lift and two assist to pick res up and put in bed, skin assessment completed, no injuries noted, will continue to monitor, call light in reach. Resident description: Stated he was trying to pee and that urinal is junk. Immediate action taken: Applied (non-slip pad) to seat of w/c. Notes: IDT (interdisciplinary team) Note: Staff witnessed (R4) attempting to use urinal when he slid from w/c. He did not hit his head and was immediately assessed. Root cause: slipping/sliding from w/c. New intervention: (non-slip pad) to w/c.On 6/1/26 at 10:25 AM, V18, CNA, stated We have to look in a resident's care plan to see what fall interventions are in place. There is no fall book or anything else to look at. We do have report sheets that we can share things like falls or change in transfer types of things.On 6/1/26 at 10:05 AM, V1, Administrator, stated I would expect all staff to ensure that resident's fall interventions are in place at all times and to monitor high fall risk residents to keep them safe from falls.2. R13's Care Plan, dated 4/21/2026, documents that R13 is at risk for falls and injuries r/t (related to) medications (Ativan and Norco). Medical Factors: History of Falls. 4/21/26 Resolved: Provide adequate lighting. 4/27/2026 Reacher at bedside. Replace LAL (low air loss) mattress with pressure relieving mattress. 05/06/2026 Mat at bedside when in bed.R13's admission Nursing Assessment, dated 4/21/2026 at 3:40 PM, documents that R13 is alert to person, place, and time, unsteady gait, poor balance, Fall Interventions: Maintain bed in lowest position.R13's Incident Report, dated 4/27/2026, documents that Resident had an unwitnessed fall from bed. Sent to ER (emergency room) for evaluation. R13's Pertinent Diagnosis: Altered Mental Status, Osteoarthritis, and Weakness. It also documents that This nurse was called into resident room by CNA (Certified Nurse Assistant). Upon entering room, it was observed resident was on her back with her calves on the bed and her head towards the floor. Over the bed table slightly behind her left shoulder. Resident air mattress inflated properly and draw sheet and bed pad were underneath resident on floor. Resident Description: Resident stated that she was trying to reach the thing that was on the floor and slipped out of bed and hit her head.The facility's Final Report and Conclusion of Incident, not dated, documents that On 4/27/26, resident experienced an unwitnessed fall from her bed. immediate assessment was completed by nursing staff. The resident was noted to have hematoma and change in condition. Resident was transferred to the emergency room for further evaluation. At the hospital, the resident was evaluated and diagnosed with a cerebrovascular accident.R13's Health Status Note, dated 4/27/2026 at 3:54 PM, documents that Note Text: This nurse was called into resident room by CNA. Upon entering room, it was observed resident was on her back with her calves on the bed and her head towards the door. Over the bed table slightly behind her left shoulder. Resident air mattress inflated properly and draw sheet and bed pad were underneath the resident on floor. The resident stated that she was trying to reach the thing that was on the floor and slipped out of bed and hit her head. Resident assessed for injury, Vitals attempted to be taken, emergency services were called, emergency contact, (V4) was called, resident taken to (local) hospital for further evaluation. DON (Director of Nursing) and MD (Doctor) aware.On 5/26/2026 at 10:00 AM R13 observed lying in bed. No floor mat in place. Frequent observations on 5/27/2026 no floor mat in place. On 5/28 at 9:00 AM R13 lying in bed. No floor mat in place. In 5/28/2026 at 9:49 AM observed R13 in bed with mat on floor.On 5/26/2026 at 1:46 PM V5, Licensed Practical Nurse, stated that she had walked past the room and R13 was in bed. V5 stated that 5 min later the CNA informed her R13 was on floor. Head and upper body out of bed on floor. Feet on bed. V5 stated that she knew due to the way R13 was laying that R13 hit her head. V5 stated that R13 is on blood thinners, and she transferred R13 immediately. V5 stated that R13 was on an air loss mattress. V5 stated that R13 has attempted to transfer self in the past. V5 stated that the bed was not in its lowest position, it was at least knee height. V5 stated that during her assessment she identified a skin tear to R13's arm.On 5/27/2026 at 9:20 AM V2, DON, stated that when R13 was admitted she made attempts to transfer (continued on next page)		

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F 0689 Level of Harm - Actual harm Residents Affected - Few	self without assist. V2 stated that the staff found R13 on the floor and notified the nurse assessed and sent the resident to ER. V2 stated that the cause of the fall was a stroke. V2 stated that she had documentation from the hospital that documented this. When asked to provide this documentation, V2 provided documentation from hospital. The hospital documentation provided by V2 does not document or indicate R13's fall was a result of a stroke as stated by V2. On 5/28/2026 at 9:00 AM V1, Administrator, stated that R13's fall was due to the air mattress. V1 stated that the air mattress was put in place a few days prior to the fall. V1 stated that although R13 made attempts to transfer self R13 had not fallen prior to the mattress being put in place. R13 stated that interventions were put in place prior to the fall. R13 stated that she expects those interventions to be in place. V1 stated that interventions were put in place after the fall and she expects those interventions to be put and remain in place. On 5/28/2026 at 9:50 AM V18, CNA Coordinator, stated that they are notified of the fall interventions by the nurse. V18 stated that all staff are responsible for putting the fall interventions in place. V18 stated that she is not sure why the R13's floor mats were not in place this week. V18 stated that they did put them in place today. On 5/28/2026 at 9:55 AM V26, CNA, stated that she is assigned to R13 today. V26 stated that she is not sure why the fall mats weren't in place this week. V26 stated that they are in place now. V26 stated that they are informed of the interventions in the communications book.3. R5's Care Plan, dated 1/20/2026, documents that At risk for falls and injuries r/t Medications (tramadol, Remeron, and gabapentin). Medical Factors History of Falls prior to admission, double BKA (below the knee amputation), requires assistance with mobility. Bed in lowest position. Orient to room. Provide adequate lighting. PT to eval and treat if indicated. 02/27/2026 - dycem between mattress and sheet. Reposition resident to middle of bed as he allows. R5's Minimum Data Set, dated [DATE], documents that R5 is moderately cognitively impaired and requires substantial/maximal assist to roll left and right (The ability to roll from lying on back to left and right side, and return to lying on back on the bed). R5's Full QA Report, not dated, documents that R5 had a fall on 2/27/2026, Resident found on floor on back. Conclusion: IDT Note: Resident found on floor on back. Resident states he was trying to roll over in bed but pulled his legs toward edge of bed causing them to be stuck under rail Resident stated he tried to straighten back out but pulled wrong way causing his body to slide off mattress. Root cause: Sliding from bed New Intervention: Dycem on mattress under sheet. Problem Statement: Resident was trying to roll over in bed but pulled his legs toward edge of bed causing them to be stuck under rail. he then states he tried to straighten back out but pulled wrong way causing his body to slide off mattress. R5's F/U (follow up) Occurrence Note, dated 2/27/2026 at 8:00 PM, documents that Note Text: Incident Note: res found on floor on back. res states he was trying to roll over in bed but pulled his legs toward edge of bed causing them to be stuck under rail. He then states he tried to straighten back out but pulled wrong way causing his body to slide off mattress. Rom (range of motion) wdl (within define limits). neuro checks wdl. denies hitting head. no apparent inj (injury). assisted back to bed via staff. Md (doctor) don and poa (power of attorney) aware. call light in reach. matt on floor next to bed. bed in lowest position. On 5/26/26 at 2:30 PM R5 stated he has had falls - stated he has the air mattress, and he did not have side rails or anything on his bed and fell off bed while transferring due to it's slickness. R5 stated that since then, they (staff) put side rails on his bed and they keep an incontinence pad under him. R5's Full QA Report, not dated, documents that R5 had a fall on 4/5/2026. It also documents Conclusion: IDT Note: Resident was in bed and repositioned self. Resident got himself too close to edge of bed and slid from bed. Root cause: repositioned self incorrectly; slide from bed New Intervention: Assist with repositioning resident to middle of bed as he allows. R5's F/U Occurrence Note, dated 4/5/2026 at 12:54 PM, documents that Note Text: Incident Note: res observed on floor in room next to bed ,stated he was too close to the side of the bed and with the mattress he has he just slid out ,moves all extremities WNL (with in normal limits) for res, denies any pain at this time, body assessment completed, no injuries noted, states he did not hit head. On 5/28/26 at 9:08 AM, R5 stated when he fell out the bed, he didn't have any dycem or non-slid/slip pad beneath him and does not have any now. On (continued on next page)		

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F 0689 Level of Harm - Actual harm Residents Affected - Few	5/28/2026 at 1:25 PM V13, Licensed Practical Nurse, stated that she was here when R5 fell. V13 stated that she observed him on the floor with back against bed. V13 stated that R5 informed her that he got too close to the edge and slid out of the bed. V13 stated that the air loss mattresses are slick. V13 stated that when R5 was on the floor he had a white sheet on him. V13 stated that she did not see a non-slid/slip device.4. R500's Care Plan, dated 3/4/2026, documents that R500 is at risk for falls and injuries r/t (related to) History of Falls, weakness, HTN (hypertension). Also has a dx (diagnosis) of macular degeneration and has poor vision.R500's Fall Risk Assessment, dated 3/5/2026, documents that R500 is a high fall risk.R500's Health Status Note, dated 3/8/2026 at 1:17 AM, documents that Note Text: Resident transferring to w/c (wheelchair) assisted by staff member and fell to floor, staff member states resident went limp, Nose and forehead bleeding. Resident alert, answering questions appropriately. B/P (blood pressure) 203/110, 76, 20, 95% on RA (room air). MD (doctor) notified, will send to ER (emergency room) for evaluation.R500's Final Report and Conclusion of Incident, not dated, documents that on 3/8/2026 The CNA was in the bathroom assisting the resident's roommate when the resident hit her call light, also needing assistance to bathroom. Resident sat herself up on the side of the bed. Staff adjusted her (R500) legs and the bed was adjusted to wheelchair height and placed to the left of the resident. Staff had placed gait belt around the resident the resident then stood up to get into her wheelchair, as she was bending at the waist to sit down the resident had gone 'limp at that time. Staff attempted to get a better hold of the resident; however, it was unsuccessful, and the resident fell to floor hitting her headfirst. The resident was assessed by nursing staff and was sent to (Local Hospital) for further evaluation from change of condition, being on aspirin therapy and hitting her head from the fall. It also documents BIMS (Brief Interview of Mental Status) 8, History of falling, weakness, Macular Degeneration, and Preglaucoma as diagnosis. Injury Subdural hematoma, T1 spinous fx (fracture) and [NAME] compression fx.V29's, Certified Nurse Assistant, written statement, not dated, documents that V29 responded to call light. R500 informed V29 that she (R500) needed to use the bathroom. V29 brought wheelchair in from the hall. Remove covers from over R500. Assisted R500 onto side of bed. Buckled gait belt around R500. Grabbed R500 under shoulder. R500 slow turned her body. Reached back for wheelchair with left. R500 never had a hold of the wheelchair before going limp and face planted.V32's, CNA, Written Statement, dated 5/8/2026, documents at 1:20 AM V32 was sitting at the nurse's station. Heard a loud gasp from the hall. Entered the room and observed R500 lying face down on the floor next to the chair. She was badly bleeding from her nose and forehead.V33's, CNA, Written Statement, dated 5/8/26, documents that V33 was at the nurse's station. Heard loud noise and gasp. Entered room R500 face down on the floor with a puddle of blood under R500's face.R500's (Local Hospital) CT (Computed Tomography) OF THE HEAD WITHOUT CONTRAST, dated 3/8/2026, documents that Findings: Moderate-sized scalp hematoma overlying the anterior midline frontal bone.R500's (Local Hospital) CT CERVICAL SPINE WITHOUT CONTRAST, dated 3/8/2026, documents a possible subtle hairline fracture of the spinous process of T2.On 6/1/2026 at 4:17 PM V29 stated that she was there when R500 fell. V29 stated that R500 needed to use the bathroom. V29 stated that R500 sat on side of the bed with a little assistance for V29. V29 stated that she did put the gait belt on R500. V9 stated that R500 stood up. V29 stated that she had a slight hold of the gait belt. V29 stated that she was holding onto it (gait belt) a little. V29 stated that she did not have a tight hold onto the gait belt. V29 stated that R500 went limp and down to the floor. V29 stated that she did not have a hold of R500 as she went down. V29 stated that she (R500) had balance problems and had episodes of going limp prior to the fall. V29 stated that she thought R500 only needed partial assistance and did not need to have a hold on to the gait belt.On 6/1/2026 at 4:35 PM V2, Director of Nursing, stated that the gait belt is to be applied to the resident tightly with a 2 finger width. V2 stated that the staff is to have a tight grip hold of the belt when transferring the resident. 1 hand on the side and 1 hand on the back. V2 stated that at no time is the employee to be grabbing for other things while transferring. V2 stated that V29 and R500 are about the same size. V2 stated that with V29 only having a slight grip on the gait belt (continued on next page)		

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F 0689 Level of Harm - Actual harm Residents Affected - Few	V29 could not have held onto R500, prevented the fall or transferred R500 safely. The facility's GAIT BELT POLICY ACKNOWLEDGEMENT FORM, not dated, documents Policy: It is this facility's staff responsibility to assure that gait belts are used with all transfers and transport of residents not full independent, to assure safety for the residents and staff. Responsibility: The gait belt is a mandatory part of the Certified Nursing Assistant uniform. Nursing Assistants are expected to use the gait belt whenever ambulating or transferring a resident for the safety of the resident and the employee. Gait belts must be used when helping the resident move from the bed, chair, or commode/toilet. An employee who is injured or caused an injury to a resident because of failure to properly apply and use a gait belt is subject to disciplinary action, which may include termination. The facility's: Fall Prevention Program/Protocol, dated 07/01/23, documents that the Program Interpretation and Implementation: Based on previous evaluations and current data, the staff will identify interventions related to the resident's specific risks and causes to try to prevent the resident from falling and try to minimize complications from falling. Fall Risk Factors: 1. Environmental factors that may contribute to the risk of falls include: c. incorrect bed height or width. It also documents Resident-Centered Approaches to Managing Falls and Fall Risk 1. The interdisciplinary will implement a resident-centered fall prevention plan to reduce the specific risk factor(s) of falls for each resident at risk (based on the falls assessment results) or with a history of falls. 5. If falling recurs despite initial interventions, staff will implement additional or different interventions, discontinue ineffective interventions, or indicate why the current approach remains relevant. 6. If underlying causes cannot be readily identified or corrected, the team will try various interventions, based on assessment of the nature or category of falling, until falling is reduced or stopped, or until the reason for the continuation of the falling is identified as unavoidable. The resident, and/or responsibility, the physician and therapy department may be involved in the process for a holistic evaluation. 7. The team shall identify and implement relevant interventions (e.g., hip padding or treatment of osteoporosis, as applicable) to try to minimize serious consequences of falling. 8. Position-change alarms will not be used as the primary or sole intervention to prevent falls but rather will be used to assist the staff in identifying patterns and routines of the resident. The use of alarms will be monitored for efficacy, and staff will respond to alarms in a timely manner.		