

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

Printed: 07/18/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145406	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/19/2025
NAME OF PROVIDER OR SUPPLIER Randolph County Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 312 West Belmont Sparta, IL 62286	
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 - 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 implement care plan fall interventions as documented for 2 of 3 residents (R1, R2) reviewed for falls in the sample of 6. Findings Include: 1. R1's admission Record, print date of 10/27/25, documented R1 has diagnoses including malignant neoplasm of female breast, neoplasm of brain, epilepsy, cerebral infarction, and dysphagia. R1's MDS (Minimum Data Set), dated 8/29/25, documented R1 is cognitively intact although at time of interview R1 was lethargic and confused. R1's Care Plan Report, undated, documented R1 has a terminal diagnosis related to metastatic breast cancer. This care plan also documented R1 is at risk for falls with interventions including low bed at all times, 15-minute checks to ensure proper bed positioning, and floor mat with an initiation date of 10/18/25. R1's Incident Report, date 10/18/25, documented CNA (Certified Nurse Assistant) came to this nurse, resident's father was in her room and said resident climbed out of her bed and fell/sat on her floor. R1's Incident Report, dated 10/22/25 at 11:30 AM, documented CNA reported to nurse that resident was sitting on the floor in front of her bed. Father was in the room with resident, reported that she was sitting on the side of the bed and slid out onto the floor. R1's Incident Report, dated 10/22/25 at 9:50 PM, documented CNA reported to this nurse at this time that resident was found sitting on the floor. This nurse immediately went to resident's room and observed resident sitting on the floor with her back resting against her bed, this nurse ask resident how the incident occurred, resident stated she was trying to get out of bed. It continues, plan of care ongoing. Immediate action: with increased confusion family states they will remain at bedside. On 10/23/25 at 12:20 PM R1 was observed resting on a low bed, no mat was observed on the floor next to the bed as care planned. R1's father V8 was present. Surveyor asked V8, R1's father, if facility staff have ever brought a floor mat into R1's room to place beside her bed. V8 stated no and that a staff person mentioned it but R1 has never been given one. V8 stated R1 fell twice yesterday, and he feels he cannot leave her room due to her having falls. V8 stated he went into the hospice sitting area for a break because the chairs are more comfortable and when he came back to R1's room he found her on the floor. V8 stated he has been staying with R1 around the clock because of her condition and fall risk. V8 stated there is never enough staff in nursing homes and it usually takes more than 15 minutes for someone to answer R1's call light. Surveyor asked V8 if facility staff have been checking on R1 at least every 15 minutes as documented in her care plan and V8 stated no. On 10/23/25 at 1:45 PM surveyor requested to review the 15-minute check logs for residents on the 2nd floor. CNA V4 handed the stack of stapled 15 minutes checks to surveyor and surveyor did not observe any 15-minute checks for R1. Surveyor asked V4 if staff have been completing 15-minute checks on R1 and V4 stated the nurse gives us these 15-minute checks and she is not listed. V4 then looked at R1's care plan and stated, it does say 15-minute checks and she is supposed to have a mat on the floor. Surveyor asked V4 if she knew R1 was supposed to have a mat next to her bed and V4 replied we get report information from the nurse, we don't have time to go through the care plans. She (R1) has not had a mat nor been on 15-minute checks. 2. R2's admission Record, print date of 10/23/25, documented R2 has diagnoses including disorientation, osteoarthritis, (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: 145406
		If continuation sheet Page 1 of 4

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	hyperlipidemia, anxiety disorder, hypertension, and depression. R2's MDS, dated [DATE], documented R2 is moderately cognitively impaired although at time of interview R2 was severely cognitively impaired. This MDS also documented R2 requires substantial to maximal assistance with transfers. R2's Care Plan Report, undated, documented R2 is high risk for falls related to gait/balance problems, incontinence, and unaware of safety needs. Interventions include ensure resident is wearing appropriate footwear when ambulating or mobilizing in wheelchair. R2's Incident Report, dated 10/20/25, documented this nurse was notified by CNA that this resident was on the floor in her room. Upon entering resident's room noted resident lying on her left side against the wall in front of her WC (wheelchair). Immediate action taken: Assessed for injuries. Noted hematoma to center of forehead and to the left side of her forehead. Scant bleeding from her left cheek. Very small scrape to left cheek. Cleansed with NS (normal saline) and LOTA (left open to air). Sat resident up on her buttocks. No c/o pain other than a headache. Assisted resident off the floor x2 assist and into her WC. Noted that resident's glasses were broken on the left side. VS (vital signs) obtained. Noted elevation in resident's BPs. On call doctor notified. Order given to sent to ER for evaluation to rule out a brain bleed. On 10/23/25 at 12:13 PM R2 was observed in the dining room in her wheelchair. R2 was observed with bilateral black eyes and R2 was wearing plain white socks. No non-skid material was on the bottom of R2's socks. On 10/27/25 at 12:08 PM V2 DON (Director of Nursing) stated she expects fall interventions to be in place per the care plan. V2 stated (R2) is supposed to have non-skid socks or shoes on at all times when she is up in her wheelchair. V2 stated she was not aware (R1) did not have her interventions in place on 10/23/25. The facility's Fall Policy, review date of 6/14/23, documented Mission Statement - to identify residents at risk for falls and provide guidelines for prevention and treatment post fall. All residents upon admission shall be assessed by the licensed nurse using the Fall Risk Assessment Form. This form will be updated quarterly, annual, significant change, or post fall episode. It continues, Post Fall - resident is assessed by the licensed nurse for potential injury and obtain treatment as necessary with MD guidance, responsible party is also notified. All falls are investigated to determine cause (avoidable or unavoidable), correction and prevention. Vital signs and condition are monitored by licensed nurse, care plan adjusted as needed to prevent additional falls. Care plan interventions reviewed with POA (Power of Attorney) and residents as needed.		

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to provide enough CNAS (Certified Nurse Assistants) to ensure residents receive assistance with care including toileting in a timely manner. These failures have the potential to affect all 53 residents residing in the facility. Findings Include:1.R1's admission Record, print date of 10/27/25, documented R1 has diagnoses including malignant neoplasm of female breast, neoplasm of brain, epilepsy, cerebral infarction, and dysphagia.R1's MDS (Minimum Data Set), dated 8/29/25, documented R1 is cognitively intact although at time of interview R1 was lethargic and confused. R1's Care Plan Report, undated, documented R1 has a terminal diagnosis related to metastatic breast cancer. This care plan also documented R1 is at risk for falls with interventions including low bed at all times, 15-minute checks to ensure proper bed positioning, and floor mat with an initiation date of 10/18/25. On 10/23/25 at 12:20 PM R1 was observed resting on a low bed, no mat was observed on the floor next to the bed as care planned. R1's father V8 was present. Surveyor asked V8, R1's father, if facility staff have ever brought a floor mat into R1's room to place besides her bed. V8 stated no and that a staff person mentioned it but R1 has never been given one. V8 stated R1 fell twice yesterday, and he feels he cannot leave her room due to her having falls. V8 stated he went into the hospice sitting area for a break because the chairs are more comfortable and when he came back to R1's room he found her on the floor. V8 stated he has been staying with R1 around the clock because of her condition and fall risk. V8 stated there is never enough staff in nursing homes and it usually takes more than 15 minutes for someone to answer R1's call light. Surveyor asked V8 if facility staff have been checking on R1 at least every 15 minutes as documented in her care plan and V8 stated no.2.R4's admission Record, print date of 10/27/25, documented R4 has diagnoses including unspecified dementia, hypothyroidism, parkinsonism, hypotension, and benign prostatic hyperplasia. R4's MDS, dated [DATE], documented R4 is severely cognitively impaired although at time of interview R4 appeared alert and oriented. This MDS also documented R4 requires substantial to maximal assistance with toileting hygiene. R4's Care Plan Report, undated, documented R4 has an ADL (activities of daily living) self-care performance deficit related to aggressive behavior and impaired balance. R4 has limited physical mobility related to Parkinson's disease and requires assist of 1 with ambulation. R4's care plan also documented R4 has functional bladder incontinence related to activity intolerance, dementia, and impaired mobility with interventions including assist to the bathroom every 2 hours while awake. On 10/23/25 at 12:07 PM R4 and his wife V7 were interviewed regarding facility staffing. V7 stated evening shift has been bad and she complained again about staffing at the care plan meeting last week. Day shift staffing is okay. V7 stated R4 doesn't get toileted timely and sometimes she just takes him to the bathroom herself, so he doesn't have an accident. V7 stated 2 CNAS on the evening shift for the first floor is not enough. V7 stated sometimes it takes almost an hour to get R4's call light answered. R4 stated the facility does not have enough CNAS and it takes a long time to get his call light answered.The facility Grievance Form for R4, dated 8/5/25, documented issue: call lights, description: waited over 20 minutes for someone to answer light she took her husband to the bathroom herself. (Adult diaper) was soaked, once in the bathroom no one came to help, when returned to room staff came in with a terrible attitude. Investigation: wife took resident to restroom after being told staff was assisting other. Nurse paged over intercom for aid. Upon entering room wife stated, there is never any help around here. 3.R5's admission Record, print date of 10/27/25, documented R5 has diagnoses including unspecified fracture of left humerus, hypothyroidism, anxiety disorder, essential hypertension, atherosclerotic heart disease, nontraumatic intracerebral hemorrhage in hemisphere, and COPD (Chronic Obstructive Pulmonary Disease). R5's MDS, dated [DATE], documented R5 is cognitively intact and requires partial to moderate assistance with toileting and substantial to maximal assistance with donning footwear. R5's Care Plan Report, (continued on next page)		

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	undated, documented R5 uses a wheelchair, needs assistance in transfers, and R5 is on oxygen per nasal cannula. On 10/23/25 at 12:25 PM R5 stated there's never enough staff in a facility. The staff try as hard as they can to answer the call lights, but it takes quite a while on all shifts. R5 stated we need more staff.4.R6's admission Record, print date of 10/27/25, documented R6 has diagnoses including atherosclerotic heart disease, urine retention, hypertension, obesity, osteoarthritis, abnormalities of gait and mobility, cerebral infarction, paroxysmal atrial fibrillation, and dizziness. R6's MDS, dated [DATE], documented R6 is cognitively intact and requires substantial to maximal assistance with transfers. On 10/27/25 at 9:08 AM R6 stated he is the President of the Resident Council and that he does not think the facility has enough CNAS. Surveyor asked R6 what shifts need more CNAS and R6 replied all of the shifts need more. R6 stated residents complain about lack of CNAS at every Resident Council meeting.On 10/27/25 at 1:22 PM R6 stopped Surveyor and stated another thing, people aren't getting walked like they are supposed to. I am supposed to be walked every day and it has been over 2 weeks since they have walked me. Surveyor asked R6 if the facility has a Restorative CNA and R6 replied I don't know but they just don't have the staff to walk us like they are supposed to.R6's Care Plan, undated, documented nursing rehab/restorative: walking program - staff to ambulate to or from all meals. On 10/23/25 at 11:58 AM V5 CNA stated the new administrator said we can run 6 CNAS on day shift and that is not enough because most of the residents are 2 assists for transfers plus there are too many tasks, they want us to complete on top of all our other duties. We used to have 2 shower CNAS and they cut 1 so now we have to do showers also. When we had 2 shower CNAS they would help float.On 10/23/25 at 12:03 PM V6 CNA stated, the new administrator cut staff, there has been an increase in resident falls, residents don't always get showers as scheduled, and residents are complaining about lack of staff.On 10/23/25 at 2:22 PM V10 CNA stated the facility has frequently been staffed with 2 CNAS on the first floor and 2 CNAS on the second floor on evening shift. V10 stated it is not always possible to complete all the tasks and residents are complaining about not getting showers. V10 stated the facility no longer has a shower CNA. V10 stated staff have complained to management and they said it's enough staff with the census.On 10/23/25 at 2:30 PM V11 CNA stated the facility often has just 2 CNAS on each floor during the evening shift and it is not always possible to get showers completed plus it takes a while to get the call lights answered when there are only 2 CNAS on a floor.On 10/23/25 at 2:37 PM V12 CNA stated the days she works they only have 2 CNAS on each floor on evening shift. V11 stated what management expects the CNAS to do is not doable with 4 CNAS in the building. V11 stated we're getting more residents, but the staffing has decreased. V12 stated most of the residents on the second floor have to be transported downstairs via the elevator to the dining room for dinner and it is very difficult to get the residents transported back and forth when there are just 2 CNAS on each floor.On 10/27/25 at 12:05 PM V2 DON (Director of Nursing) stated they staff the facility based on census. V2 stated around the second week of October the census got high enough that they increased the CNA staffing to 3 CNAS on each floor on the evening shift.On 10/27/25 at 1:17 PM Surveyor reviewed the daily staff schedules with V2 DON. V2 confirmed that the facility was staffed with 2 CNAS on the first floor and 2 CNAS on the second floor on 10/1/25, 10/2/25, 10/3/25, 10/11/25, 10/13/25, and 10/19/25. The facility's Detailed Census Report for October 2025, dated 10/27/25, documented the census was 49 on 10/1/25, 10/2/25, and 10/3/25. This form documented the facility census was 52 on 10/11/25, 10/13/25, and on 10/19/25.On 10/27/25 at 11:53 AM V1 Administrator stated the facility does not have a staffing policy and they follow the state guidelines. V1 stated when she started working at the facility, they were running 8 CNAS on the day shift for 43 residents, that's craziness, we can't survive with that staffing ratio. V1 stated she took down 1 shower aid position and they now run 6 CNAS on the day shift plus a shower aid and 6 CNAS on the evening shift.The facility's Daily Census report, dated 10/27/25, documented there are 53 residents residing at the facility with 28 residents residing on the first floor and 25 residing on the second floor.		