STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145488	A. Building B. Wing	08/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Rushville Nursing & Rehab Ctr	135 South Morgan Street Rushville, IL 62681

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. (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:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(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	Based on record review and interview the Facility failed to initiate appropriate fall interventions for one of four Residents (R6) reviewed for falls in a sample of six.Findings include:The Facility Fall Clinical Protocol Policy, revised 8/2008, documents: as part of the initial assessment, the Physician will help identify individuals with a history of falls and risk factors for subsequent falling; staff will continue to collect and evaluate information until either the cause of falling is identified, or it is determined that the cause cannot be found, or that finding a cause would not change the outcome or management of falling and fall risk; based on the preceding assessment, the staff and physician will identify pertinent interventions to try to prevent subsequent falls and to address risks of serious consequences of falling; and staff and physician will monitor and document the individual's response to interventions intended to reduce falling or the consequences of falling.The Facility Resident Rights Policy, dated 2007, documents Personal Safety, the Resident has the right to expect safety as the Facility practice and environment are concerned.R6's current Care Plan, documents: diagnoses including Cerebrovascular Accident/CVA, Osteoarthritis, Depression, Diabetes and Depression; Activities of Daily Living performance deficit related to CVA and Hemiplegia affecting the right dominant side; and behaviors of agitation with difficulties falling/staying asleep; short term memory deficits. The Care Plan also documents the 2/14/25 fall interventions as educating on keeping wheelchair brakes locked; the 4/21/25 fall interventions as sign placed in room reminding to wear non-skid socks or shoes at all times; and the 7/5/25 fall interventions as non-skid strips placed on bathroom floor and a sign in room and bathroom reminding to lock wheelchair brakes.R6's Minimum Data Set/MDS documents: Section C (Cognitive Patterns), dated 3/18/25, documents moderate cognitive loss on R6's Brief Interview for Mental Status/BIMS (score 8/15); and Section GG (Functional Abilities) requiring substantial/maximal assistance with transfers.The Facility Fall Report, dated 2/1/25 through 2/28/25, documents R6's fall on 2/14/25 at 1:00 pm. R6 was found on the floor in the common area.The Facility Fall Report, dated 4/1/25 through 4/30/25, documents R6's fall on 4/21/25 at 2:20 pm. R6 was found on the floor in the common area.The Facility Fall Report, dated 7/1/25 through 7/31/25, documents R6's fall on 7/5/25 at 12:00 am, in R6's bathroom. R6's Event Report, dated 2/14/25 at 1:00 pm, documents R6 slid from unlocked wheelchair while trying to grab a boxed puzzle from the bottom shelf on the television stand in the common area (Day Room). The Event Report documents that R6 was screaming for help on right side, wheelchair unlocked and not near him; R6 stated that R6 slid from the wheelchair while trying to grab a puzzle.R6's Fall Details Report, dated 4/21/25 at 2:20 pm, documents R6 was found lying on right side on floor next to toilet, call light was off, wheelchair not in use and was off to side and R6 only wearing socks on feet. The Fall Details Report documents an intervention of a sign placed in R6's room to remind to wear non-skid socks or shoes at all times.R6's Event Report, dated 7/15/25 at 12:00 am, documents R6 had an unwitnessed fall in R6's bathroom. R6 was found sitting on the bathroom floor with wheelchair against the wall from R6. R6 stated that when R6 attempted to transfer back to wheelchair, the wheelchair rolled away from R6, causing R6 to land on the floor.On 8/14/25 at 11:50 am, V10 (Restorative Nurse/Licensed Practical Nurse) stated, I do understand that just educating (R6) or placing signs in (R6's) room was probably not the best intervention, given his cognition.On 8/14/25 at 1:00 pm, V2 (Director of Nursing) stated, We probably need different interventions for (R6) other than just educating or putting signs in (R6's) room. V2 verified that R6 is cognitively impaired and that the fall interventions were not appropriate for R6.