STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145538	A. Building B. Wing	11/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Beecher Manor Nrsg & Rehab Ctr	1201 Dixie Highway Beecher, IL 60401

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. (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 - Actual harm Residents Affected - Few	Based on interview, and record review, the facility failed to have safety measures in place to prevent a fall. This failure led to a resident sustaining a 3-centimeter laceration to the left parietal scalp, requiring 3 staples for closure. This applies to 1 of 5 residents (R1) reviewed for falls. The findings include:R1's electronic health records showed that on 10/22/25, R1 was admitted with diagnoses including a displaced fractured left femur, Parkinson's disease, and a history of repeated falls.On 11/12/25 at 9:21 am, V5 Certified Nurse's Assistant (CNA) said that on 10/30/25 around 10 am, she was providing personal hygiene and dressing R1 while R1 was in bed. At this time R1's upper body was shaking and jerking heavily. V5 said that she had never provided care for R1 before. V5 said she also had not received a report from the off going staff or the nurse on duty about R1. V5 said that she thought that with R1 jerking so heavily that she needed a 2nd staff and a full body mechanical lift. V5 said that she should have done this before she sat R1 on the side of the bed. V5 said she slid R1 to the side of the bed and put her in a sitting position without a 2nd staff assisting. V5 said that she reached for a wipe to clean R1's face when R1 jerked again and fell off the bed and on to the floor, causing a laceration to her head. R1's 10/30/25 hospital records showed that R1 had a 3-centimeter laceration to the left parietal scalp requiring 3 staples for closure. On 11/12/25 at 9:52 am, V6 LPN (Licensed Practical Nurse) said that it is the facility's policy that you have 2 staff present when putting a resident on the side of the bed prior to transferring them with a sit-to-stand. On 11/12/25 at 5:20 pm, V2 DON (Director of Nursing) said that no staff should put a resident on the side of the bed when the resident is heavily jerking without getting a 2nd staff first. V2 said that if you don't, you are putting the resident at risk of falling. V2 said that her expectations and the facility's practice and policy is always have 2 staff with the sit-to-stand including prior to sitting the resident on the side of the bed. On 11/12/25 at 3:24 pm, V9 (CNA) said that she was V5's partner on 10/30/25 and V5 never asked her to assist her with R1. V9 said that you must have 2 staff present when you put a resident on the side of the bed prior to transferring them with a sit-to-stand mechanical lift.On 11/12/25 at 12:16 pm, V8 (R1's Primary Care Physician) said that R1's fall on 10/30/25 caused a laceration to her head. V8 said that in his professional opinion 2 staff were needed before R1 was placed in a sitting position on the edge of the bed. V8 said that this was important because R1 has Parkinson's, and she was jerking at the time. V8 said that if 2 staff had been there, they could have prevented the fall and laceration.On 11/12/25 at 5:15 pm, V1 (Administrator) said that 2 staff should have been present before putting R1 on the edge of the bed in a sitting position since R1's body had been jerking. V1 said that this should have been done for safety. R1's 10/23/25 - 12/2/2025 Physical Therapy Evaluation & Plan of Treatment showed that R1 is dependent on staff for chair/bed-to-chair transfer. The facility's Fall and Fall Risk, Managing policy dated August 2008, showed that based on previous evaluations and current data the staff will identify interventions related to the resident specific risks and causes to try to prevent the resident from falling and try to minimize complications from falling. Staff will identify and implement relative interventions. to try to minimize serious consequences of falling. R1's 10/22/25 Fall Risk Assessment showed that R1 scored 14 and was categorized as a high risk for falls. The document showed R1 had decreased muscular coordination with contributing factors of neuromuscular/functions and orthopedic conditions.