STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145546	A. Building B. Wing	04/28/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MT Zion Health & Rehab Center	1225 Woodland Drive Mount Zion, IL 62549

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 Note: The nursing home is disputing this citation.	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 observation, interviews, and record review, the facility failed to ensure appropriate supervision for a resident identified as a high fall risk and failed to implement care-planned fall interventions for one of three (R5) residents reviewed for accidents from a sample of five. This failure resulted in R5 sustaining a fall that resulted in a displaced fracture in the upper portion of R5's right leg. Findings:The facility's Fall Prevention Program/Protocol, dated 7/01/2023, documented that the purpose of the policy is to provide guidance to facility staff regarding the prevention and reduction of falls within the facility. The policy identifies the Director of Nursing and/or designee as responsible for ensuring that all staff are aware of the program's elements.This policy documented that the interpretation and implementation of the fall prevention program are based on prior evaluations and current data, and that staff are to identify and implement interventions specific to each resident's risk factors and causes in an effort to prevent falls and minimize complications.This policy outlined resident-centered approaches to fall prevention, including that the interdisciplinary team will implement an individualized fall prevention plan to address specific risk factors for residents identified as at risk based on fall assessment results or history of falls. The team is also responsible for identifying and implementing relevant interventions (e.g., hip protectors or treatment of osteoporosis, as applicable) to reduce the risk of serious injury.Additionally, the policy documented that early prevention and fall detection measures will be performed, including:Fall risk assessments completed upon admission, quarterly, and with any significant status change;Resident-specific fall interventions made accessible to all staff in a fall binder located at each nurse's station for quick reference; andResidents identified as high risk (scoring 10 or higher on the fall risk assessment) will have a visual identifier placed on the room door and on assistive or mobility devices to alert staff of the fall risk.R5's Minimum Data Set (MDS), dated [DATE], documented that R5 had moderate cognitive impairment. This MDS further documented that R5 required supervision or touching assistance from staff for chair-to-bed and bed-to-chair transfers, and that walking 10 feet was not attempted due to the resident's medical condition or safety concerns.R5's Care Plan, with an initiation date of 1/28/2026, identified the resident as being at risk for falls and injuries related to generalized weakness, pneumonia, dementia, and Chronic Obstructive Pulmonary Disease (COPD). This Care Plan documented that R5 sustained falls on 3/13/2026, 3/18/2026, 3/19/2026, 3/25/2026, and 4/11/2026.This Care Plan documented an intervention, dated 3/13/2026, to place a floor mat next to R5's bedside, and an intervention, dated 1/28/2026, to maintain R5's bed in the lowest position.R5's Fall Risk assessment dated [DATE] documented that R5 was at high risk for falls.R5's Electronic Health Record (EHR) contained a health status note dated 3/25/26 that documented writer was notified by the Social Services Director (SSD) that R5 was observed on the floor. Upon assessment, R5 was observed by writer laying on her right side next to her bed with her head at the head of bed. R5 was yelling out complaining of right hip pain rated at a 10/10. No bleeding or visible injuries noted.A state report form documented that on 3/25/26 at 5:30 p.m., R5 was observed on the floor in her bedroom. Staff had been in a short time prior, and resident was asleep in her bed. Shortly after the (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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(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 Note: The nursing home is disputing this citation.	SSD heard a resident yell help while walking down the hallway and noticed R5 laying on her right side next to her bed with her head at the head of her bed. Bed was in low position, socks and house slippers on both feet, call light was clipped to R5 but not activated. R5's roommate stated R5 was sitting on the side of bed attempting to go to the bathroom and fell out of bed. This report documented that R5 had moderate cognitive impairment.On 4/27/2026 at 12:04 p.m., R6 (R5's roommate) stated she witnessed R5's fall on the day R5 was sent to the hospital with an injury. R6 stated R5 was sitting on the side of the bed, which R6 described as approximately knee height (about 2 feet off the ground), when R5 slipped off the side of the bed and fell.R6 stated that no fall mats were in place at the time of the fall and pointed to fall mats that were observed on the bed during this interview. R6 stated those mats were placed on the floor after R5 fell. R6 further stated that R5 had a history of frequent falls out of bed.On 4/27/2026 at 12:25 p.m., V9, Licensed Practical Nurse (LPN), stated she was the nurse caring for R5 on 3/25/2026 when R5 fell. V9 stated V3, Social Services Director (SSD), informed her that R5 was found lying on her back on the floor beside the bed, with the head positioned toward the head of the bed and feet toward the foot of the bed. V9 stated upon entering R5's room she found R5 on the floor and the bed was approximately knee height and that no fall mats were in place at the time of the fall.V9 stated that a CNA had taken R5 to the bathroom prior to the incident and that she was unsure why fall mats were not placed on the floor, noting that the Kardex indicated mats were to be in place. V9 stated that R5 was a known fall risk with a history of previous falls and that a call, don't fall sign was in place. V9 stated R5 was unable to explain how the fall occurred and was observed grabbing the right buttock and stating, ouch, ouch, please help me.On 4/27/2026 at 12:55 p.m., V3, Social Services Director (SSD), stated that R6 (R5's roommate) alerted staff that R5 had fallen and was on the floor complaining of hip pain. V3 stated she found R5 lying on her right side in a fetal position next to her bed, which was approximately at knee height.On 4/27/2026 at 1:22 p.m., V15, Licensed Practical Nurse (LPN), stated she responded to R5's room after hearing commotion in the hallway. V15 reported that she observed R5 lying on her right side on the floor next to the bed, with her back facing the bed, and complaining of right hip pain. V15 stated the bed was approximately knee height (about 3 feet off the floor) and confirmed that no floor mats were in place at the time of the fall.On 4/27/2026 at 2:02 p.m., V14, Certified Nurse Assistant (CNA), stated she had been in R5's room approximately 20 minutes prior to the fall and that a newly hired CNA, V16, whom she was training, was the last staff member to see R5 prior to the incident. V14 reported that shortly thereafter, she was alerted that R5 was on the floor and, upon entering the room, observed R5 lying on her right side. V14 stated that R5 reported she attempted to get up to close her door and fell while trying to stand. V14 confirmed that R5 was a known fall risk but was unsure whether required fall interventions, including fall mats, were in place at the time of the fall.On 4/27/2026 at 2:36 p.m., V16, CNA in training, stated she recalled a fall that occurred on her first day of training on 3/25/2026. V16 reported that she entered R5's room to assist the roommate (R6) and observed R5 sitting on the edge of the bed. V16 stated that R5 did not request assistance, and she was unsure why R5 was sitting on the side of the bed.V16 stated that approximately ten to fifteen minutes later, she and her trainer (V14) were informed that R5 was found on the floor next to the bed. V16 stated there was not a fall mat in place at that time.On 4/28/2026 at 11:05 a.m., V2, Director of Nursing (DON) stated V16, CNA should have responded to R5 sitting on the side of the bed and should have recognized that appropriate fall interventions were not in place. V2 further stated that V14, CNA should have remained with V16, as it was her first day of training and she was not yet familiar with the residents.X-ray results in R5's EHR, dated 03/25/26, document an acute, mildly displaced fracture of the right greater trochanter following the fall.