STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145572	A. Building B. Wing	04/01/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Graham Hospital	210 West Walnut Street Canton, IL 61520

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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 0686 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to implement physician ordered pressure relieving interventions to prevent the development of pressure ulcers and failed to initiate a pressure ulcer care plan as soon as a pressure ulcers were identified for one of one resident (R1) reviewed for pressure ulcers in the sample of 21. These failures resulted in R1 developing a stage two facility acquired pressure ulcer to the right gluteus and a stage four pressure ulcer to the right base of the big toe that required mechanical debridement. The facility's Skin Assessment, Wound Prevention, and Care Policy dated 4/2025 documents, (The facility) shall provide care, treatment, and services to: 1. Identify those at risk for skin breakdown. 2. Promote comfort and mobility. 3. Reduce or relieve pressure and maintain skin integrity. 4. Provide appropriate interventions to manage pressure ulcers and minimize infection. 5. Provide learning opportunities. Prevention of skin breakdown is primarily a nursing responsibility. The most effective means of preventing skin breakdown or relief of pressure on the skin, maintenance of adequate circulation, hydration, and an adequate diet. Staff should educate the patient and family regarding the importance of repositioning and proper way to change positions. Staff should remind patients to shift their weight every 15 minutes while sitting in a chair and to change position regularly. Staff should encourage patients to maintain or increase mobility or activity as appropriate. Staff should monitor the patient's frequency of repositioning. Patients who are dependent on the staff for repositioning: a. Reposition the patient every two hours as needed, depending on the patient's condition. Minimize shearing and friction on the skin when cleansing, providing care, or moving the patient. b. Use mechanical loading, support surfaces, and repositioning devices. 3. Preventative interventions for all patients at risk: b. Place a pillow under the patient's legs, suspending the heels, to decrease the pressure placed on the patient's heels. c. Encourage and assist with repositioning every two hours and as needed. f. Avoid layers of padding between patient's skin and relief surface. k. Evaluate and document preventative interventions. 5.Interventions shall be incorporated into the patient's plan of care, via automated process based on nursing evaluation. Nursing shall continue to evaluate and revise as the condition of the patient indicates. A pressure ulcer is localized injury to the skin and/or underlying tissue usually over a bony prominence, as a result of pressure, or pressure in combination with shear and/or friction. Stage Two Pressure Ulcer is partial loss of dermis presented as a shallow open ulcer with a red, pink wound bed, without slough (dead tissue). May also present as an intact or open/ruptured serum-filled blister. Presents as a shiny or dry shallow ulcer without slough or bruising. Stage Four Pressure Ulcer is full thickness tissue loss with exposed bone, tendon, or muscle. Slough or eschar (black or brown layer of dead tissue) may be present on some parts of the wound bed. Often include undermining and tunneling. Stage Four ulcers can extend into muscle and/or supporting structures make osteomyelitis possible. Exposed bone/tendon is visible or directly palpable.R1?s most recent MDS (Minimum Data Set) assessment dated [DATE] documents R1 was cognitively intact, was dependent on staff for toileting, rolling left and right, and personal hygiene, was at risk for developing pressure ulcers, had a stage II facility acquired pressure ulcer, and was on a turning-repositioning program.R1's Wound Clinic Notes dated 3/19/26 documents, Wound: Right Gluteus Pressure Injury. Primary Dressing Xeroform (Petroleum (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 0686 Level of Harm - Actual harm Residents Affected - Few	Based Dressing). Wound Measurements 4.2 cm (centimeters) by 5.0 cm by 0.1 cm. Stage Two. Date Acquired 7/29/25. Wound: Right Foot Pressure Ulcer. Date Acquired 10/20/25. Wound measurements 0.6 cm by 0.6 cm by 0.1 cm. Stage Four. Necrotic 67-100 percent. Eschar. Open wound debridement. Off-loading: Right Gluteus and Right Foot: (pressure relieving) cushion to wheelchair, turn and reposition every two hours, and heel protectors at all times. Primary Dressing Xeroform.R1's current Care Plan documents, Active 7/20/25 high risk for impaired skin integrity. This same Care Plan does not include pressure relieving interventions or interventions to address R1's current pressure ulcers to the right gluteus and right foot, or pressure relieving interventions to prevent pressure ulcers prior to R1's pressure ulcer development to the right gluteus or right foot.R1's Electronic Care Charting dated 3/30/26 from 7:00 AM through 1:12 PM, was documented as R1 remained in the same seated position in a chair for the entire time period. This same documentation indicated R1 did not refuse turning and repositioning during this timeframe.R1's Electronic Care Charting dated 3/31/26 from 7:00 AM through 10:58 AM, was documented again as R1 remained in the same seated position in a chair throughout the entire time period, with no documentation indicating R1 refused repositioning.On 3/30/26 from 10:30 AM through 12:50 PM and 3/31/26 from 10:15 AM through 1:15 PM, R1 was seated in a padded wheelchair in the dining room with bilateral heels resting on the wheelchair footrests. R1 was not wearing heel protector boots during these timeframes.On 3/31/26 at 1:30 PM R1 was lying in bed on her right side. R1 did not have on heel protector boots. V13 (Agency Registered Nurse) provided wound cares to R1's right gluteus pressure ulcer and R1's right base of the big toe pressure ulcer. R1's right gluteus pressure ulcer was pink, and dime sized. R1's pressure ulcer to the base of the right big toe was approximately 0.5 cm red and covered with a hardened yellow scab.On 3/30/26 at 10:15 AM R1 stated, The sores on my foot and butt are bedsores from lying in bed too long.On 3/31/26 at 11:10 AM V2 (Director of Nursing) stated, I know (R1) has a physician's order somewhere to be turned and re-positioned every two hours. Turning and repositioning every two hours is our (facility staff's) standard. (R1's) care plan does not include pressure relieving interventions to prevent pressure ulcers or current interventions to address (R1's) pressure ulcers. I have worked here since January 2026 and have not had time to update (R1's) care plan. (R1's) wounds to the right gluteus and right foot were caused by pressure.On 3/31/26 at 1:36 PM V17 (CNA/Certified Nursing Assistant) stated, (R1) is not on a turning and repositioning program. (R1) sits up all day long and then lies down later in the afternoon. (R1) does not wear heel protector boots throughout the day. We (the facility) only put (R1's) heel protectors on at night.On 3/31/26 at 2:30 PM V18 (Wound Nurse Practitioner) confirmed R1 has orders to be turned and repositioned every two hours and should be wearing heel protector boots at all times. V18 confirmed R1's wounds to the right gluteus and base of the right big toe were caused by pressure and were facility acquired.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. Based on interview and record review the facility failed to ensure residents' comprehensive care plans were individualized to reflect each resident's specific needs, conditions, and preferences. This failure affects all 21 residents who reside at the facility. Findings include: The facility's Care Plan Policy revised 3/10/25 documents the individualized care plan is used to outline the care in which the patients shall receive during their stay. A plan of care which defines patient or family outcomes within a pre-established time frame, prompting continuity of care using interventions to meet expected outcomes. The documented plan of care is based on the patient's goals and time frames, settings, and services required to meet those goals. Goals need to be realistic, individualized, patient centered, measurable, dated, the care plan needs to be reviewed daily to determine if goals are being met. The facility's Patient/Resident Care Plan and Care Conference revised September 2025 documents Patients/residents shall have an individualized care plan. The resident care plan helps to provide quality patient/resident care. The facility's CMS (Centers for Medicare and Medicaid Services) Form 671 dated 3/30/26 and signed by V1 (Administrator) documents 21 residents reside within the facility. On 4/01/2026 at 9:40 AM, V2 (Director of Nursing) stated he is responsible for initiating and revising care plans for all residents in the facility. V2 reported he develops comprehensive care plans based on resident diagnoses and revises them as new diagnoses are identified. V2 further stated he does not have the capability within the facility's electronic medical record system to customize interventions for individual residents, and they plan to eventually switch to a new system better suited for long term care. V2 confirmed that all 21 residents currently residing in the facility do not have individualized interventions reflected in their care plans.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview, and record review the facility failed to ensure sanitary conditions were maintained during food preparation and service to prevent cross-contamination and foodborne illness, in accordance with professional standards for food safety. This failure has the potential to affect all 21 residents who reside at the facility.Findings include:The facility's CMS (Centers for Medicare and Medicaid Services) Form 671 dated 3/30/26 and signed by V1 (Administrator) documents 21 residents reside within the facility.On 03/30/2026 at 11:05 AM, V8 (Cook) was observed cleaning main food preparation areas with a wash rag while food on the steam table remained uncovered. The same wash rag was placed on the counter and subsequently used to clean a food thermometer between temperature checks of the food on the steam table. During continued observation, V8 was observed wiping sauce from the lasagna with her fingers onto the same wash rag used to clean the counters and thermometer. When checking hamburger temperatures, the initial holding temperature was 142 F, V8 stated the hamburgers would be returned to the steamer for reheating. V8 handled the pan using the same contaminated wash rag and placed the rag back on the counter. At no time during the observation did V8 perform hand hygiene or don gloves. V8 continued to use the same wash rag for cleaning surfaces and the thermometer throughout food handling activities.On 03/31/2026 at 8:10 AM, V11 (Dietary Supervisor) stated that staff are expected to perform hand hygiene and wear gloves when handling food. V11 further stated that thermometers should be cleaned between uses with an alcohol swab.On 03/31/2026 at 9:40 AM, V15 (Dietary Director) stated that if a wash rag is used for cleaning a thermometer, it should be clean and used for a single purpose only. V15 confirmed that V8 should have performed hand hygiene, worn gloves, and not used the same rag for multiple tasks. V15 further stated the facility does not have a policy or procedure to guide staff on proper techniques for obtaining food temperatures.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. Facility failures resulted in two deficient practices.A. Based on interview and record review, the facility failed to establish and maintain an effective infection prevention and control program by failing to perform surveillance to track and monitor residents and staff illnesses and differentiating between resident facility-acquired and community acquired infections. This failure has the potential to affect all 21 residents residing in the facility.B. Based on observation, interview, and record review the facility failed to implement Enhanced Barrier Precautions while providing incontinent cares for one of 12 residents reviewed for infection control practices in the sample of 21.Findings include:A. The facility's Infection and Prevention Control Program Plan, dated March 2024, documents Policy: Based on current scientific knowledge, accepted practice guidelines, and applicable law and regulations, the hospital shall provide written policies and procedures related to Infection Control, surveillance and prevention for all departments of the organization. To assist in the prevention of the transmission of infections the entire staff is responsible for adhering to policies and procedures related to infection control. 6. Goals and Function: b. To conduct a surveillance program of infections with the Hospital through the collection and analysis of data that is meaningful in the prevention of the spread of infections. 7. Infection Control Professional: a. A Registered Nurse with knowledge of epidemiology practices, microbiology, and infectious disease, who has completed or shall complete a course in Infection control approved by the Center for Disease Control (CDC) and directs the Infection Control Program. c. Responsibilities: vii. Approves actions to prevent or control infection based on evaluation of surveillance reports of infections and of the infection potential among patients and hospital personnel. x. Coordinator of Employee Health to protect patients and employees. 8. Surveillance/Healthcare Acquired Infections and Healthcare Acquired Conditions: a. Total house surveillance is conducted and monitored weekly. Surveillance of infections, both community acquired, and healthcare acquired infections/conditions, is conducted to identify baseline information about the frequency and type of endemic infections in order to permit rapid identification of deviations from the baseline. 9. Reporting of Employee Health: a. All employee absences are reported to the Infection Control /Employee Health coordinator. This information is used to assess for potential areas of an outbreak. b. The Employee Health Report contains data that is pertinent to all immunization and vaccination compliance, exposures, employee illness, any other pertinent data and is given to the Director of Human Resources upon completion of new employee immunization completion and upon request. The facility's Infection Prevention Surveillance Policy, dated May 2024, documents Policy: Concurrent and retrospective review will be used to accomplish surveillance of the Hospital regarding infection disease in order to: 1. Identify- a. Unusual Pathogens, b. Any occurrence of hospital acquired infection, c. Hospital Acquired Infections that exceed the usual baseline levels, d. Clusters of Infections, and e. Epidemics. 2. Review and evaluate data trend analysis generated by surveillance activities. 3. Recommend and institute intervention strategies when appropriate to reduce the risk of future occurrence. 4. Monitor effectiveness of prevention or intervention strategies in reducing hospital acquired infection risk. 5. Sources of data shall be: a. Daily statistics report, b. census and bed availability report, c. diagnosis defining risk patient, d. isolation, e. elevated temperatures, f. respiratory difficulty, g. wounds, h. diarrhea, i. rash. 6. Microbiology and serological data: a. medical records, b. temperature records, c. progress notes, d. medication record, e. laboratory data, f. radiographic data. 8. Collected data shall be recorded and tabulated as to site, service, unit location, physician(s), risk factors, pathogens, and treatment. Sites of infections reported will be urinary tract, respiratory tract, (Eyes, Ears, Nose, Throat, Mouth, and Lower), circulatory (Systemic and localized), surgical wound, (superficial incision, deep incision, and organ/space), skin/soft tissue, reproductive tract, gastrointestinal tract, bone/joint and undetermined. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	The Investigation Protocol for Infection Surveillance, dated May 2024, documents Policy: The Hospital shall investigate infections and determine the following: Appropriate isolation is being employed, staff are observing isolation precautions, staff are employing appropriate work practice controls to prevent transmission, patients are on the proper antibiotic regimen for the pathogen per susceptibility, staff are well and have no contagious symptoms present. On 3/31/26 at 12:02 PM the facility's infection control surveillance logs were all reviewed from January 1st, 2026, through March 31st, 2026, and does not contain a tracking log of resident illnesses or employee illnesses, nor does it include whether residents' illness were facility or community acquired. On 3/31/26 at 12:20 PM, the V4 (Infection Control Nurse) who has held the position since July 2025, stated she has not been tracking employee illness since she has started the position. V4 stated, I was told to no longer track employee illnesses because we (the facility) are not allowed to ask why the staff called in. V4 verified, while an antibiotic tracking log is maintained for residents each month, it does not consistently specify whether a resident's infection was house-acquired or community acquired, nor does it include a comprehensive record of all resident illnesses other than infections that are being treated with an antibiotic. B. The facility's Enhanced Barrier Precautions policy dated 3/2025 documents, In addition to Standard Precautions, use of Enhanced Barrier Precautions for specified patients in the Skilled or Long Term area who have a colonized MDRO that they are not in contact isolations for, have an indwelling device, or have an acute or chronic wound. 3. Personal Protective Equipment: a. Gown and gloves are required to be worn when performing high contact cares for residents. These include dressing, bathing/showering, transferring, changing linens, providing hygiene, changing briefs while assisting with toileting, device care, and wound care. A gown and gloves will be worn when working with patients who are in Enhanced Barrier Precautions while in their room or in the therapy gym. R1's current Physician's Orders documents an order to place R1 in Enhanced Barrier Precautions. These same orders document R1 has an indwelling urinary catheter and wounds to the right foot and right gluteus. On 03/30/2026 at 10:15 AM R1 had a sign located on her doorway that indicated R1 was placed in Enhanced Barrier Precautions. R1 was in bed lying on her right side. V5 (CNA/Certified Nursing Assistant) and V6 (CNA) were providing incontinent cares. R1 had a bowel movement in her adult brief. V5 and V6 had gloves on but did not have gowns on while providing R1's incontinent cares. On 3/30/26 at 10:30 AM both V5 and V6 verified they were not wearing gowns while providing incontinent cares for R1. V5 stated, We did not have time to put on gowns. On 3/30/26 at 2:00 PM V4 (Infection Control Nurse) stated all employees providing direct cares to any resident placed in Enhanced Barrier Precautions should be wearing gowns and gloves while providing direct cares.

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F 0882 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Designate a qualified infection preventionist to be responsible for the infection prevent and control program in the nursing home. Based on interview and record review, the facility failed to ensure the designated Infection Preventionist completed specialized Infection Prevention and Control (IPC) training prior to performing the role. This failure has the potential to affect all 21 residents residing in the facility. Findings include:The facility's CMS (Centers for Medicare and Medicaid Services) Form 671 dated 3/30/26 and signed by V1 (Administrator) documents 21 residents reside within the facility.The facility's Infection and Prevention Control Program Plan, dated March 2024, documents Policy: Based on current scientific knowledge, accepted practice guidelines, and applicable law and regulations, The hospital shall provide written policies and procedures related to Infection Control, surveillance and prevention for all departments of the organization. To assist in the prevention of the transmission of infections the entire staff is responsible for adhering to policies and procedures related to infection control. 7. Infection Control Professional: a. A Registered Nurse with knowledge of epidemiology practices, microbiology, and infectious disease, who has completed or shall complete a course in Infection control approved by the Center for Disease Control (CDC) and directs the Infection Control Program.On 3/31/26 at 12:07 PM V1 (Administrator) stated V4 (Infection Control Nurse) has not completed the Infection Prevention and Control training to her knowledge. V1 is unable to provide a certification of completion for Infection Prevention and Control for V4/Infection Preventionist. On 3/31/26 at 12:20 PM V4 (Infection Control Nurse) stated she has been the Infection Preventionist since July 2025 and has yet to complete the required Infection Preventionist training. V4 stated, I started to complete some of the infection control modules, but since I didn't complete them all I never received a certification of completion.

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. Based on observation, interview, and record review, the facility failed to ensure a resident's indwelling urinary catheter bag was covered to maintain the resident's dignity for one of one resident (R19) reviewed for dignity in a sample of 21.Findings include:The Illinois Long-Term Care Ombudsman Program Resident Rights Booklet, dated 11/18, documents Your rights to dignity and respect: Your facility must treat you with dignity and respect and must care for you in a manner that promotes your quality of life.R19's MDS (Minimum Data Set) Assessment, dated 3/26/26, documents R19 is severely cognitively impaired and has an indwelling catheter. R19's Physician Orders, dated 3/13/26, indicates R19 has an indwelling urinary catheter. On 3/30/26 at 10:27 AM R19 was sitting in her recliner in her room with the door open. R19's urinary catheter drainage bag was observed hanging on the side of R19's bed (facing the door) and was not covered by a dignity bag. The drainage bag was one fourth full of yellow urine. On 3/31/26 at 11:42 AM V1 (Administrator) stated R19's urinary catheter bag should be covered with a dignity bag if able to be seen from R19's room. V1 stated, I know we have the privacy bags to cover urinary catheter drainage bags. I am not sure why (R19) did not have a privacy bag covering her catheter bag.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to accurately code the MDS (Minimum Data Set) Assessments for two of two residents (R5 and R8) reviewed for MDS Accuracy in the sample of 21. Findings Include: CMS's (Centers for Medicare and Medicaid Services) RAI (Resident Assessment Instrument) Version 3.0 Manual Section P: Restraints and Alarms dated 10/2025 documents, 'Intent: The intent of this section is to record the frequency that the resident was restrained by any of the listed devices or an alarm was used, at any time day or night, during the seven-day look-back period. Assessors will evaluate whether or not a device meets the definition of a physical restraint or an alarm and code only the devices that meet the definitions in the appropriate categories. 1.R8's current Physician's Order dated 3/16/26 documents R8 utilizes bilateral upper side rails for positioning and bed mobility. R8's MDS assessment dated [DATE] documents R8 is cognitively intact and uses bedrails as a restraint daily. On 3/30/26 at 10:00 AM R8 stated she uses her side rails to position herself in bed. R8 stated her side rails do not restrain her. 2. R5's current Physician Orders dated 3/16/26 documents R5 utilizes bilateral upper side rails for positioning and bed mobility. R5's MDS Assessment (dated 3/18/26), documents R5 is moderately cognitively intact and uses side rails as a restraint daily. On 3/30/26 at 2:35 PM V2 (Director of Nursing) stated R5 and R8 use side rails for positioning. V2 stated R5 and R8's side rails are not being utilized as restraints. On 3/30/26 at 2:45 PM V10 (MDS Coordinator) stated, I have not received any formal training regarding coding section P Restraints of the MDS. I have been doing MDS Assessments since January 2026. (R5) and (R8) do not use side rails as restraints. (R5) and (R8's) Section P of their MDS Assessments are inappropriately coded.

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to develop and implement a restorative range of motion program for one of one resident (R6) reviewed for limitations in range of motion in the sample of 21.Findings include:The facility's Restorative Range of Motion Policy dated 2/2026 documents, The restorative Range of Motion program shall provide the patient with the assistance required to maintain and improve joint mobility and promote a greater sense of well-being, thus assisting in the prevention of contractures, pain, and edema. Objectives: 1.To maintain and improve range of motion to an extremity that has decreased ability and movement. 2. To prevent a decrease in patient mobility due to loss of ROM (Range of Motion). 3. To increase joint flexibility, thus leading to greater ease of ADLS (Activities of Daily Living) and transfers. A physician's order shall not be required for initial assessment of the Restorative Nurse Assistant program but shall be required for establishing treatment. The program shall be conducted by a Restorative Nurse on a one-to-one basis with the patient.R6's MDS (Minimum Data Set) assessment dated [DATE] documents R6 is severely cognitively impaired, has functional limitations in range of motion to one side of the upper extremity and one side of the lower extremity, is dependent on staff for ADLs (Activities of Daily Living), and receives no restorative nursing programs, including range of motion programs.R6's current Care Plan documents R6 has a diagnosis of CVA (Cardio-Vascular Accident) with Right Sided Sensory Deficit. This same Care Plan documents R6 has a problem of impaired mobility as evidenced by compromised ability to move, range-of-motion limitation, decreased muscle strength, impaired coordination, imposed restriction of movement, and reluctance to move. This same Care Plan does not include any restorative programs to address R6's impaired mobility.On 3/31/26 at 9:45 AM R6 was sitting in a wheelchair in his room. R6's right arm and right leg were flaccid. V13 (Agency Registered Nurse) stated, (R6) had a stroke and is unable to move his right arm or right leg.On 3/30/26 at 1:30 PM V14 (R6's Private Caregiver) stated, I am here almost every day to help take care of (R6) as a private sitter. I have never seen any staff do range of motion with (R6).On 3/30/26 at 3:44 PM V2 (Director of Nursing) stated, (R6) does not get any type of restoratives or range of motion exercises. We (the facility) do not have a restorative nurse that does assessments or establishes restorative programs for the residents.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145572	A. Building B. Wing	04/01/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Graham Hospital	210 West Walnut Street Canton, IL 61520

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 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail. Based on observation, interview, and record review, the facility failed to assess and identify entrapment risk associated with the use of side rails and document alternatives to side rails with outcomes prior to installing side rails for one of two residents (R5) reviewed for side rail use in a sample of 21.Findings include:The facility's Side Rails and Entrapment Policy, dated February 2026, documents, Policy: It is the policy of this facility to identify and reduce safety risks and hazards commonly associated with bed rail use. A duo-faceted approach shall be used to achieve sustainable quality outcomes, including 1) regular bed maintenance and 2) individual bed rail evaluations. In response to the requirement of providing for a safe, clean, comfortable, and homelike environment, the facility's regular preventative maintenance program shall include regular inspection of all bed systems (rails, frames and mattresses, and operation components) to ensure they are clean, comfortable, and safe. The facility shall also ensure individual resident bed rail evaluations are performed on a regular basis. Individual bed rail evaluations shall include data collection analysis and determination of potential alternatives to bed rail use. When bed rail(s) are deemed necessary and appropriate, the facility shall provide education to residents or resident's representative pertain to the risk and benefits of bed rail use. The facility's priority is to ensure safe and appropriate bed rail use. Purpose: The purpose of this policy is to assist resident representatives, physicians and facility staff to determine if resident use of side rails is safe and appropriate. The Interdisciplinary Team shall use data collected from regular bed inspections and induvial side rails assessments and evaluations to assist in care planning and positive resident outcomes. Definitions: Bed Rail: (also referred to as side rails, bed side rails, and safety rails are constructed of metal or rigid plastics and are available in various sizes including full length rails, half rails, and quarter rails to align with resident-specified needs. Bed rails may be positioned in various locations on the bed including upper or lower, either or both sides. No matter what the purpose for the use, bed rails and other bed accessories including transfer bars, trapeze, bed enclosures, although prescribed to include functional independence with bed mobility and transfers, may increase resident safety risk. Entanglement: TH estate of body or limb, being wrapped or twisted in any tubing, cords, cables and wires. Entrapment: The state of body or limb being caught, trapped or entangled such as in the space in or about the bed rail, mattress or bed frame. Procedure: 1. Resident Assessment: iv. Assessment of need for special equipment or accessories: 1. Assess resident to identify appropriate alternatives prior to installing bed rails or other bed mobility devices, 2. Assess resident for risk of entrapment from bed rails prior to installation, 3. Review risk and benefits with resident and representative. 2. This facility utilizes all alternative processes to minimize/eliminate the use of all physical side rails including bed rails, side rails and mobility enhancers. Staff shall implement alternatives prior to implementing a restraint.R5's Physician Order's, dated 3/30/26, documents the following, but not limited to diagnoses: Anxiety with Depression, History of Completed Stroke, General Weakness, Fall Downstairs, Strain of Left Elbow, and Neck Muscle Strain. These same Physician Orders document the following physician order Start date: 3/16/26-Bilateral Upper Rails. Reason for side Rail use: Positioning/Bed Mobility, get in and out of bed, and spatial awareness.R5's MDS (Minimum Data Set) Assessment, dated 3/18/26, documents R5 is moderately cognitively impaired, requires dependent assistance with rolling side to side and transfers, and uses side rails daily.R5's Medical Record does not include a side rail assessment to assess and identify entrapment risk associated with the use of side rails or documented alternatives tried prior to the implementation of side rails. On 3/30/26 at 10:15AM, R5's bed had bilateral quarter side rails in an upright position. On 3/30/26 at 2:30 PM V2 (Director of Nursing) verified R5 did have side rails and verified a bed rail assessment had not been completed along with documented alternatives prior to the implementation of side rails. V2 stated, We do not do side rail assessments or try alternatives prior to implementing the side rails on the skilled care unit.