STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145760	A. Building B. Wing	09/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Robinson Rehab and Nursing	600 East Robinwood Drive Robinson, IL 62454

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

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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- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, observation, and record review the facility failed to provide supervision and implement effective interventions to prevent falls for 1 (R1) of 3 residents reviewed for falls in the sample of 12. This failure resulted in R1 sustaining a fall that caused a fracture of left knee and large hematoma of scalp and a right parietal subarachnoid hemorrhage. This past non-compliance occurred on from [DATE] to [DATE].Findings Include:R1's face sheet documents an original admission date of [DATE]. R1 has diagnoses in her electronic health record including, but not limited to dementia, dorsalgia, history of falling, abnormalities of gait and mobility, unsteadiness on feet, muscle weakness, and difficulty in walking.R1's non-medication related physician orders include but are not limited to order dated [DATE] for monitoring and prevention of adverse effects of opioid medications including, but not limited to falls, disorientation, dizziness, vertigo, and lightheadedness.R1's most recent minimum data set (MDS) dated [DATE] documents R1 has a brief interview for mental status (BIMS) score of 2 indicating R1 is not cognitively intact indicating R1 is unaware of her own safety. In section GG of same MDS it is documented R1 is dependent for all activities of daily living including transfers and mobility except eating. Section I of the same MDS documents diagnoses including, but not limited to non-Alzheimer's dementia, history of falling, muscle weakness, and abnormalities of gait and mobility.R1's most recent care plan (CP) dated [DATE] documents R1 has a focus area dated [DATE] indicating R1 is at risk for falls. Interventions related to this focus area include but are not limited to assisting R1 to always keep non-skid footwear on while R1 is up, dated [DATE]; intervention dated [DATE] documents to make sure R1's call light is always within reach; and a third intervention, undated in current care plan is to place a fall mat beside the bed to decrease the impact of falls. Another focus area on R1's CP dated [DATE] documents R1 has an alteration in her ability to care for self and needs assistance due to cognitive impairment and weakness. Interventions for this focus area include but are not limited to R1 requiring mechanical lift transfer with assist of two staff for transfers dated [DATE].R1's Final Serious Injury Incident Report date [DATE] documents on [DATE] at 11:30 am R1 was being prepared for transfer from bed to chair. Staff member stepped out into the hall to obtain the lift and resident rolled out of bed onto the floor. Resident was in the center of the bed when staff member stepped out to the lift. Resident obtained a left subtle non-displaced fracture of the medial femoral condyle as well as a right parietal subarachnoid hemorrhage. Bed was in low position when resident rolled out. Resident to return to this nursing facility today [DATE]. R1's hospital records dated [DATE] documents a computed tomography scan reading of R1's left knee showing a subtle nondisplaced fracture of the medial femoral condyle with moderate suprapatellar lipohemarthrosis. A computed tomography scan reading dated same as first, of R1's skull documents a large left frontal scalp hematoma and an equivocal right parietal subarachnoid hemorrhage.On [DATE] at 11:07 AM, R1 was located in the therapy room receiving therapy. R1 had a very large hematoma noted to left of midline of forehead that extended into the scalp. There was dried blood noted to the center of the hematoma. There were also sutures present but unable to determine how many due to the dried blood. R1 had yellow, purple and blue bruising extending all the way down her face into her neck. R1 was not interviewable at that time.On [DATE] at 11:58 AM, V10, (Certified Nurse's Aide/CNA) stated on [DATE] while she was assisting R1 to get ready for lunch R1 was lying in bed. V10 stated she had left the mechanical lift outside the door of R1's room until R1 was readied for transfer from bed to wheelchair. V10 stated she left R1's bedside unattended to retrieve the mechanical lift outside R1's door of room. V10 stated when she left R1's bedside unattended R1's bed was in the lowest position and R1's side rails were up, but R1's fall mat was not placed back in the proper position of R1's bedside. V10 stated when she walked out of the room, she then heard V11(CNA) yell for her to get back in the room. V10 stated when she rushed back into R1's room she observed R1 lying on her left side next to her bed with bleeding coming from her head. V10 stated in looking back she believed she did not leave R1 in the safest possible position before leaving the bedside because she did not place R1's fall mat back at side of bed. V10 stated the protocol for getting R1 ready to transfer via use of the mechanical lift is one staff member stays at bedside while the other retrieves the mechanical lift. V10 stated she simply was not thinking, leaving R1 unattended and fall mat removed from bedside while retrieving the mechanical lift. V10 stated she believes R1's fall could have been prevented if the other staff member, V11 had been at bedside to prevent R1 from rolling out of bed, or at the least R1's injuries from the fall could have been less severe if fall mat had been in place according to R1's fall precautions. On [DATE] at