

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  145783	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  08/01/2025
NAME OF PROVIDER OR SUPPLIER  Sunrise Skilled Nur & Rehab		STREET ADDRESS, CITY, STATE, ZIP CODE  333 South Wrightsman Street Virden, IL 62690	

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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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on observation, interview and record review the Facility failed to ensure residents were supervised to prevent accidents for 1 of 3 residents (R2) reviewed for falls in the sample of 5. This failure resulted in R2 being left unsupervised in bed in the high position on a low airloss mattress causing R2 to fall from the bed sustaining multiple fractures to both legs. Findings include: R2's July 2025 Physician Order Sheet (POS) document a displaced comminuted fracture of shaft of left fibula subsequent encounter for closed fracture with routine healing (dated 7/28/2025); osteomyelitis of vertebra, sacral and sacrococcygeal region, type 2 diabetes mellitus without complications, unspecified fracture of lower end of left tibia, subsequent encounter for closed fracture with routine healing (start date 7/28/2025), unspecified fracture of shaft of right tibia, subsequent encounter for closed fracture with routine healing (start date 7/28/2025); displaced fracture of second metatarsal bone right foot, subsequent encounter for fracture with routine healing (start date 7/28/2025); muscle wasting and atrophy; abnormalities of gait and mobility; other lack of coordination; Fournier gangrene; cutaneous abscess of back; local infection of the skin and subcutaneous tissue; unspecified fracture of right calcaneus sequela, renal osteodystrophy; end stage renal disease; and weakness. R2's Minimum Data Set (MDS) dated [DATE] document R2 was cognitively intact for decision making of activities of daily living. R2's MDS documents R2 has impairments on both sides, uses a wheelchair, and is dependent on staff for most Activities of daily living and has two stage 3 pressure ulcers. R2's MDS documents for him to roll from left to right he is dependent on staff; helper does all of the work. R2's Care Plan with a Target Date of 10/26/2025 does not address falls. R2's Follow Up Occurrence Note dated 7/11/2025 at 9:00 AM, Note Text: Incident Note: Resident on floor. Says he rolled out of bed. Denies hitting head. Neuro check WNL (within normal limits). VSS (vital signs stable). Says he has pain to rt (right) elbow and rt (right) and lt (left) ankles. No new skin issues. ROM (Range of motion) present to all extremities as per resident normal. Resident moved rt arm bending at elbow and both ankles rotated per resident. Nurse Practitioner here and saw resident post fall. Extra Norco ordered to be given for c/of (complaint of) of pain. Nurse Practitioner also said to send an extra Norco to Dialysis with resident per his usual request when going to Dialysis. Resident gotten up off floor with mechanical lift per staff. R2's Investigation does not address the root cause of his fall (lack of supervision). R2's Progress Notes dated 7/11/2025 at 4:32 PM, Note Text: Resident called facility driver to tell him he is in the ER (emergency room) and was sent from dialysis. Writer called ED (emergency department) who confirmed resident was there and was sent over for L (left) ankle pain. They confirmed that there was a L (left) tibia fracture and that they are awaiting ortho to consult to determine if they will admit or splint and send back tonight. PCP (primary care physician) and wife made aware. R2's Progress Notes dated 7/11/2025 at 6:49 PM, Note Text: Writer called for update- res (resident) will be admitted for fx (fracture). They don't know if he will need surgery yet or not. R2's Verification of Incident Report date of incident 7/11/2025 at 9:00 AM, Resident rolled out of bed at 9 AM. Resident sent to ER (emergency room) there. ER was called for a status updated and was made aware of fractures. Immediate Action: Nurse Practitioner in building and assessed. Extra dose of Norco provided for pain management. Bolsters added to resident mattress. POA (Power of Attorney), IDPH and Ombudsman notified. Summary of investigation: Resident had a fall after rolling out of bed. Resident was seen by the wound nurse and wound NP prior to rolling out of bed. Resident was ready to get up for the day, wound nurse notified CNA (Certified Nurse's Assistant) that resident was ready to get up. When aide entered room, resident was observed on the floor. CNA notified nurse who immediately assessed. No altered skin integrity noted. Does complaint of pain to right elbow and right ankle. Resident was able to move all extremities himself with no issues, rotated ankles and moved his arms and bending them at the elbows, resident denies hitting his head. Wife was present in the room at the time of the incident and states he did not hit his head. Resident was assisted up off the floor with (mechanical lift). Placed in bed, aid got him ready for dialysis then assisted to wheelchair via (mechanical lift). Primary care NP (Nurse Practitioner) was making rounds, who also assessed resident. NP ordered an extra dose of Norco to be given and ordered for one to be sent with resident to dialysis. Resident lays on a low loss mattress, and when he rolled over, the air in the mattress went to the opposite side, causing him to roll out of bed. Bolsters were placed on air mattress for boundary awareness and as a safety intervention. CP (Care Plan) updated. Transportation driver reported that the resident had no complaints on the ride to dialysis. Once at the dialysis, resident complained of pain to RL F (bilateral lower extremities), dialysis then</p>