STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145783	A. Building B. Wing	10/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sunrise Skilled Nur & Rehab	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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145783	A. Building B. Wing	10/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sunrise Skilled Nur & Rehab	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	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on Interview, and Record Review, the facility failed to properly transfer 1 of 4 residents (R2), reviewed for appropriate safe transfers in the sample of 4. This failure resulted in R2 having a fall, sustaining a right hip fracture and ultimately passing away. The Findings Include: R2's admission Record, dated [DATE], documents R2 was originally admitted to the facility on [DATE] and was discharged on [DATE] with diagnosis of Cerebral Atherosclerosis, Dementia, Anemia, Hypertension, Atherosclerosis of Aorta, Generalized Anxiety Disorder, Major Depressive Disorder, Abdominal Aortic Aneurysm, Osteoporosis, Disorders of bone density and structure, Personal history of (healed) traumatic fracture left humerus.R2's Care Plan, dated as complete on [DATE], documents R2 has a Self-Care Deficit as Evidenced by: Needs max to dependent assistance with functional abilities related to dementia, history of fracture, impaired balance, pain, weakness, limited mobility. Interventions: Transfer: two-person physical assistance required, Bed Mobility - two-person physical assistance required, Toilet Use: two-person physical assistance required, Out of Bed Positioning: Sits in wheelchair.R2's Care Plan, dated [DATE], documents R2 has a history of self-transferring. Interventions: Provide support during transfers. It continues R2 is at risk for falls related to impaired mobility, requiring extensive assistance with transfers. Interventions: [DATE]: (full body mechanical lift device) with two assists, keep call light within reach, keep environment clutter free, keep personal belongings within reach, provide adequate lighting, (non-slip pad) for chairs, provide/reinforce use of non-skid footwear, [DATE] low bed, [DATE] mat at bedside, [DATE] night light placed in room. It continues R2 Self-Care Deficit as Evidenced by: Needs max to dependent assistance with functional abilities. Interventions: [DATE] Bed Mobility - two-person physical assistance required, [DATE] Transfer: (full body mechanical lift device) transfer with two assists.R2's Minimum Data Set (MDS), dated [DATE], documents R2 had a severe cognitive impairment and was dependent on staff for all Activities of Daily Living (ADLs).R2's Hospice admission Note, dated [DATE], documents to admit R2 to (Local Hospice) with diagnosis Cerebral Atherosclerosis.The Facility's Fall Log for the past three months, documents R2 had a fall on [DATE].R2's Fall Risk Assessment, dated [DATE], documents R2 was a High Fall Risk. R2's Fall Occurrence Note, dated [DATE] at 6:24 PM, documents Incident Description: While Certified Nursing Assistant (CNA) was transferring resident she began to buckle her legs, so CNA stated she lowered her safely to the floor. Resident statement on what was being attempted when fall occurred N/A. Resident Description of Fall: unable to give statement. Date/Time of Incident: [DATE] at 5:20 PM. Resident is alert. Residents Orientation: Person, Resident Is Exhibiting Usual Level of Orientation. Vitals: BP (blood pressure) -120/67, T (temperature) -98.2, P (pulse) -75, R (respirations) -16, SPO2 (oxygen saturation) -95. Injury Observed: Skin tear to the right elbow. Physician/Provider notified, Resident Representative notified; Resident Son, DON (Director of Nursing) notified.R2's Fall Investigation, dated [DATE], documents Incident Description: Writer was notified by CNA that resident was on the floor. CNA stated that while she was transferring resident, she had buckled her legs, and she was unable to hold resident and had to safely lower her to the floor. While lowering her to the floor, resident did hit her right elbow on the railing resulting in a skin tear. Description of Action Taken: Resident was transferred from floor to wheelchair via (full body mechanical lift device). Skin tear assessed, cleaned and treated. Note Text: IDT (interdisciplinary team) met to discuss this resident lowering to the ground. Staff was transferring resident into bed from wheelchair when her knees buckled. Aide states that resident then grabbed on to her and she lowered her to the floor. Nurse was notified and immediately assessed. MD (medical doctor) and POA (Power of Attorney) aware. Resident has a skin tear noted to her R (right) elbow. Elbow was cleaned and dry dressing applied. Wound nurse to follow. Will monitor until healed. Resident originally denied of pain initially, but the next day started to c/o (complain of) pain to the left leg. MD made aware, POA present, hospice aware - orders received for order and x-ray. PRN (as needed) Morphine utilized. Resident was assisted off floor and assisted to bed. Staff aware resident will now be a (full body mechanical lift device) lift. Padding to side rail placed for increased protection. CP (care plan) updated. No Fx. (fractures) noted, all parties aware.R2's Nursing Note, dated [DATE] at 12:56 PM, documents Resident's son is here and is concerned about the resident's complaints of pain to the left leg, explained that she had Tylenol this am and that she had not complained at all until the hospice CNA was here and bathed her yesterday and she was given morphine at that time. When this nurse asked the resident about pain this am she denied need for pain medication until the CNAs were removing her from the dining room, and she