STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146000	A. Building B. Wing	12/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Fairfield Senior Living & Rehabilitation LLC	305 N.W. 11th Street Fairfield, IL 62837

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. (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 0684 Level of Harm - Minimal harm or potential for 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 document and report a fall for 1 (R1) of 3 residents reviewed for accidents in the sample of 4.The past noncompliance occurred between [DATE] and [DATE].The Findings Include:R1's admission record dated [DATE] documented that R1 was admitted to the facility on [DATE] with diagnoses that include Parkinson's Disease without Dyskinesia, depression, sleep apnea, benign prostatic hyperplasia, essential hypertension, hypothyroidism, hyperlipidemia, and unspecified dementia.R1's MDS (Minimum Data Set) quarterly assessment dated [DATE] documented R1 has a BIMS (Brief Interview for Mental Status) score of 08 indicating R1 has moderate cognitive impairment. R1's Care Plan documents a focus area of Fall Risk - at risk for falls related to unsteady gait, interventions include: [DATE]- offer to assist resident bed when appears to be tired,[DATE] - all regular socks removed from room, gripper socks to be used as resident complies, [DATE] - bolster mattress will be added to bed as tactile reminder of bed perimeter, [DATE] - busy box to be offered to resident when he is up since resident likes to work / fix things, [DATE] - use 2 wheel walked when up, observe for safe ambulation's, Re-educate on safe walked use as needed, call light within reach, may use wheelchair as needed, and observe for unsafe actions and intervene.An Illinois Department of Public Health report form documents incident date: [DATE] documented R1 was observed on the floor in his bedroom and the resident was in no pain and had no complaints of discomfort. Resident later had complaints of pain; nurse received an order for an x-ray that revealed a subcapital right femoral neck fracture. Physician ordered to send R1 to the local hospital for evaluation and treatment. At the time of the incident, the call light was within easy reach and eyesight yet not activated. The resident was wearing appropriate footwear, and the room was free from clutter or spills. During interview with the resident, he was unable to state what happened. A bolster mattress to be applied to bed to aid in positioning and as a tactile reminder of bed perimeter, and resident to be offered a busy box when up, since resident was working on his wheelchair when he was noted in the floor.R1's Nurse's Note, documented as a late entry date of [DATE] at 5:23 P.M. documented a date of [DATE] timed 5:45 A.M. authored by V4 (Registered Nurse), documented during first morning medication pass coming from rose hall to begin giving medications to daisy hall, (R1) was seen sitting in the side of the bed with wheelchair lifted resting on (R1's) leg working on the front wheels of the wheelchair. (R1) verbalized no needs, no distress, or pain was verbalized. CNA's that came to get (R1) dressed observed (R1) sitting upright in the middle of the room (on the floor) with the wheelchair pulled over to him and leaned over working on the wheelchair. They proceed getting (R1) ready for the day and resident was assisted to the restroom and then back to the recliner.R1's Nurse's Note dated [DATE] timed 11:15 A.M. authored by V5 (Licensed Practical Nurse), documented call out to physician on call service related to complaints of severe pain to right hip with new order received for X-ray. V3 (Family Member) aware.R1's Nurse's Note dated [DATE] timed 6:26 P.M. authored by V15 (Registered Nurse) documented x-ray results received and physician notified. New order to send to emergency room for evaluation and treatment. V3 notified of results and new orders. V2 (Director of Nursing) notified of x-ray results.R1's x-ray report dated [DATE] documented under section titled Impression subcapital right femoral neck fracture with varus angulation and proximal displacement.R1's Neuro Check assessment in the Electronic Health Record documents a date and time of evaluation of [DATE] at 5:50 (am) and a Lock Date of [DATE], documents R1 was alert, pupils were reactive, hand grasps were equal, and R1 could move all extremities.On [DATE] at 1:48 P.M. V4 (Registered Nurse) stated she was the nurse caring for R1 the morning of [DATE]. V4 stated she was passing the early am medications somewhere around 5 am and R1 was observed sitting on the edge of his bed tinkering with his wheelchair. V4 stated this was a normal behavior for R1. V4 stated she did not see R1 fall or see R1 on the floor. V4 stated the staff working said that it occurred. V4 stated she assessed him, and he had no complaints of pain. V4 stated she does not consider R1's behavior of sitting on the floor a fall. V4 stated she knows there is no behavior care plan for R1 sitting on the floor. V4 stated I guess they are considering him sitting in the floor a fall. V4 stated she did not do a fall assessment or an incident report because she did not consider it a fall. V4 stated when she was leaving around 6:30 A.M. on [DATE] R1 was going to the dining room and was not having any pain. V4 stated she does not know the time that R1 was on the floor. V4 stated that the cna's got him up and put him in bed without notifying her. V4 stated the cna's told me after the fact that it happened. V4 stated that is why she did an assessment when she went in to give R1 his morning medications. V4 stated it is her expectation