STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146113	A. Building B. Wing	04/02/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Greenup Rehab and Nursing	300 North Marietta Street Greenup, IL 62428

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to report an injury of unknown origin to the state survey agency for one of three residents (R1) reviewed for accidents/injuries in the sample list of eight. Findings include: R1's Minimum Data Set, dated [DATE] documents R1 has moderate cognitive impairment and is dependent on staff for transfers. R1's February 2026 Medication Administration Record documents R1 received Eliquis (blood thinner) 2.5 milligrams by mouth twice daily.R1's Nursing Note dated 2/25/2026 at 8:25 PM documents V29 Certified Nursing Assistant (CNA) alerted nurse to bruising to R1's side. The bruising was dark purple and extended from left mid-breast over nipple to underneath R1's left armpit measuring 7.5 centimeters (cm) by 27 cm. R1 was unable to state what happened due to cognition but displayed signs of pain when area was touched. The physician, family and Administrator were notified. R1's interdisciplinary team note dated 2/26/2026 at 11:47 AM documents root cause of R1's bruising as R1 is a two person transfer with gait belt, R1 is combative with transfers, and likely due to the gait belt and transfer. Intervention to in-service staff on proper gait belt placement. There is no documentation that the facility reported this injury of unknown source to the state survey agency. On 3/31/26 at 10:45 AM V1 Administrator stated R1's bruising was identified to be due to use of gait belt. V1 stated we investigated the bruising and identified the cause within two hours, therefor it wasn't considered an injury of unknown origin and was not reported as such. On 4/2/26 at 11:25 AM V29 CNA stated V29 was assisting R21 to bed and changing R1's clothes, when R1 complained of pain. V29 found bruising on R1's left side that extended from R1's breast to her side. V29 assisted R1 the morning prior and the bruising was not there. V29 reported the bruising to V15 Licensed Practical Nurse, who said there were no reported bruising or incidents. V29 stated nothing had been reported prior and nothing had happened during V29's shift that would have caused the injury and R1 had not had any recent falls or bumping into anything. V29 stated R1 and V15 were also not sure what caused the bruising. V29 stated it did align with gait belt or also R1 leaned over the side of her wheelchair armrests at times. On 4/2/26 at 11:30 AM V2 Director of Nursing stated V2 assisted with the investigation of R1's injury, believed to be caused by gait belt. V2 stated per V1, V2 thought the facility had two hours to investigate injuries to determine the cause and since the cause was identified there was no need to report this injury. On 4/2/26 at 12:45 PM V15 stated V29 reported R1's bruising which was immediately reported to V1. V15 stated V29 said the bruising wasn't there the prior night and we weren't sure what caused the injury. V15 stated R1 was confused and didn't know the cause either. V15 stated the bruising was purple in color and was over 20 cm long stretching from armpit to across breast on left side. The facility's Elder Justice Act and Reporting Suspected Crimes Against Residents policy dated 10/1/23 documents an injury of unknown source criteria as the source of the injury was not observed by any person, the source of injury could not be explained by the resident, and the injury is suspicious due to the extent of the injury or the location such as an area not generally vulnerable to trauma. This policy documents injuries of unknown source as an example of crimes that are required by state and federal law to be reported to the state survey agency.

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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to thoroughly investigate an injury of unknown origin for one of three residents (R1) reviewed for accidents/injuries in the sample list of eight. Findings include:R1's Minimum Data Set, dated [DATE] documents R1 has moderate cognitive impairment and is dependent on staff for transfers. R1's February 2026 Medication Administration Record documents R1 received Eliquis (blood thinner) 2.5 milligrams by mouth twice daily.R1's Nursing Note dated 2/25/2026 at 8:25 PM documents V29 Certified Nursing Assistant (CNA) alerted nurse to bruising to R1's side. The bruising was dark purple and extended from left mid-breast over nipple to underneath R1's left armpit measuring 7.5 centimeters (cm) by 27 cm. R1 was unable to state what happened due to cognition but displayed signs of pain when area was touched. The physician, family and Administrator were notified. R1's interdisciplinary team note dated 2/26/2026 at 11:47 AM documents root cause of R1's bruising as R1 is a two person transfer with gait belt, R1 is combative with transfers, and likely due to the gait belt and transfer. Intervention to in-service staff on proper gait belt placement. There is no documentation for this investigation or staff interviews/statements to determine the cause of the injury. On 3/31/26 at 10:45 AM V1 Administrator stated R1's bruising was identified to be due to use of gait belt. V1 stated we investigated the bruising and identified the cause within two hours, therefor it wasn't considered an injury of unknown origin and was not reported as such. On 4/2/26 at 11:25 AM V29 CNA stated V29 was assisting R21 to bed and changing R1's clothes, when R1 complained of pain. V29 found bruising on R1's left side that extended from R1's breast to her side. V29 assisted R1 the morning prior and the bruising was not there. V29 reported the bruising to V15 Licensed Practical Nurse, who said there were no reported bruising or incidents. V29 stated nothing had been reported prior and nothing had happened during V29's shift that would have caused the injury and R1 had not had any recent falls or bumping into anything. V29 stated R1 and V15 were also not sure what caused the bruising. V29 stated it did align with gait belt or also R1 leaned over the side of her wheelchair armrests at times. On 4/2/26 at 12:45 PM V15 stated V29 reported R1's bruising which was immediately reported to V1. V15 stated V29 said the bruising wasn't there the prior night and we weren't sure what caused the injury. V15 stated R1 was confused and didn't know the cause either. V15 stated the bruising was purple in color and was over 20 cm long stretching from armpit to across breast on left side.On 4/2/26 at 11:30 AM V2 Director of Nursing stated V2 assisted with the investigation of R1's injury, believed to be caused from gait belt. On 4/2/26 at 12:00 PM V1 Administrator stated V15 reported R1's bruising that evening and V1 and V2 conducted the investigation that evening. V1 stated phone calls were made to V19 Physical Therapy Assistant, V5 CNA, and V29 CNA. V1 stated R1 has dementia and will sometimes stop while walking and gets combative. V19 reported that V19 was transferring R1 from the couch to the wheelchair and R1's legs gave out like R1 was going to sit and the gait belt caused the bruising. At 1:55 PM V1 stated V1 had no documentation to provide for R1's investigation including staff interviews or statements. The facility's Elder Justice Act and Reporting Suspected Crimes Against Residents policy dated 10/1/23 documents an injury of unknown source criteria as the source of the injury was not observed by any person, the source of injury could not be explained by the resident, and the injury is suspicious due to the extent of the injury or the location such as an area not generally vulnerable to trauma. This policy documents the facility must send in an investigative report to the state survey agency within five days of the incident for injuries of unknown source and maintain evidence of a thorough investigation.

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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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to complete post fall neurological assessments for 72 hours as directed by the facility's policy for three of three residents (R1, R2, R3) reviewed for accidents in the sample list of eight. Findings include:1.) R3's Nursing Notes document: On 2/20/2026 at 7:16 PM R3 was found on the floor in the day room leaning up against the wall near a wheelchair. On 2/20/2026 at 7:51 PM after prior fall, R3 fell again while V17 Certified Nursing Assistant (CNA) was walking ahead of R3 as R3 would not let V17 guide R3 into the dining room. R3 obtained an 8 centimeter (cm) by 7 1/2 cm hematoma (bump) to the back of her head. On 2/23/2026 at 11:03 AM V14 Licensed Practical Nurse (LPN) was in the living area with another resident and saw R3 stand up with R3's blanket at her feet causing her to fall backwards and hit her head on the ground. R3 had a scalp hematoma on the right side/back of her head. On 3/13/2026 at 3:00 AM V5 and V29 CNAs heard a thud from R3's room and found R3 lying on her back on the floor of her room near the sink and R3 had a small hematoma on the back of her head. R3's Incident Audit Report dated 3/16/26 documents R3 had an unwitnessed fall at 7:15 AM. R3 was found crawling on the floor of her room as V5 walked past to the dining room. R3 had an open area to the left/back side of her head that measured 0.3 cm by 0.2 cm. R3's Neurological Assessment Flow Sheets dated 2/20/26, 2/23/26, 3/13/26 and 3/16/26 document to assess every 15 minutes x4, then hourly x4, then every 4 hours x19 hours (a total of 24 hours). There is no documentation that R3's post fall neurological assessments were continued for a total of 72 hours after each fall. R3's Hospital Discharge summary dated [DATE] documents R3 was hospitalized on [DATE] following a recent fall with multiple rib fractures, tiny right anterior pneumothorax (collapsed lung), subdural hematoma (collection of blood between the brain and outer covering), and skull fracture. R3's head CT dated 3/7/26 documents small acute to subacute appearing left cerebral convexity subdural hematoma without midline shift and non-displaced right occipital skull fracture suggested. On 4/1/26 at 12:00 PM V18 LPN stated V18 completed post fall neurological assessments for R3, which are completed for 24 hours. On 4/1/26 at 1:18 PM V14 LPN completed post fall neurological assessments for R3, which are documented on the neurological assessment form. 2.) R1's Nursing Note dated 2/16/26 at 7:37 PM documents R1 was heard yelling for help and was found sitting on the floor, an unwitnessed fall, and neurological assessments were initiated. R1's February 2026 Medication Administration Record documents R1 received Eliquis (blood thinner) 2.5 milligrams (mg) twice daily. R1's Neurological Assessment Flow Sheet dated 2/16/26 documents to complete for 24 hours post fall. There is no documentation that these assessments were continued for 72 hours after R1's fall.3.) R2's Physician Order dated 1/14/26 document Eliquis 2.5 mg twice daily. R2's Nursing Notes document the following: On 2/21/2026 at 10:56 PM documents R2 had an unwitnessed fall while walking independently in her room when she tipped forward with her walker. On 2/22/2026 at 8:38 PM documents small hematoma and bruising continue to back of R2's head. On 3/3/2026 at 5:36 AM R2's spouse turned call light on to report R2 sat down on the floor but denied hitting R2's head. Neurological checks were initiated. R2's Neurological Assessment Flow Sheets dated 3/3/26 and 2/21/26 indicate to complete neurological assessments for 24 hours. There is no documentation that these assessments were continued for 72 hours after each fall. On 4/1/26 at 2:55 PM V3 Regional Administrator stated the facility's policy is for post fall neurological assessments to be completed for 72 hours and when the facility change ownership in January 2026, they did not change the forms from 24 hour monitoring to 72 hours to match the policy. On 4/2/26 at 10:08 AM V1 Administrator stated V1 was unable to find documentation that neurological assessments are completed besides the 24-hour neurological forms. The facility's Fall Reduction Policy dated 10/30/25 documents initiate neurological assessments based on the schedule on the neurological status evaluation if the fall was not witnessed, or the resident hit their head. The facility's Neurological Assessment policy dated 11/5/19 documents the following time frames for (continued on next page)

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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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	assessments: every 15 minutes x4, then every 30 minutes x2, then hourly x4, then every 4 hours x2, then every shift x7.

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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 - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to report and thoroughly investigate falls and serious injuries and failed to develop/implement fall interventions for two of three residents (R1, R3) reviewed for falls in the sample list of eight. Findings include:1.) R3's admission Minimum Data Set (MDS) dated [DATE] documents the following: R3's diagnoses include Dementia and Osteoporosis. R3 has severe cognitive impairment, is dependent on staff for toileting, is independent with walking and chair/bed transfers, and requires partial/moderate staff assistance with toilet transfers. R3 is always incontinent of bowel and bladder, is dependent on staff assist for toileting hygiene, and a toileting program has not been attempted. R3 has a history of falls within the last month prior to admitting to the facility. R3's Fall Risk Assessments dated 2/23/26, 3/12/26 and 3/13/26 document R3 had three or more falls within the last three months, R3 has balance problems while standing and walking, R3 has changes in gait when walking through a doorway, and R3's gait pattern as jerking movements or unstable when making turns. R3's active Care Plan documents: R3 as high risk for falls and R3 is unaware of safety needs, and surroundings. Fall interventions include self-15-minute checks (2/18/26) and anticipate toileting needs (2/19/26). R3's Hospital Discharge summary dated [DATE] documents R3 was hospitalized on [DATE] following a recent fall, R3 had multiple rib fractures, tiny right anterior pneumothorax (collapsed lung), subdural hematoma (collection of blood between the brain and outer covering), and skull fracture. R3's head CT dated 3/7/26 documents small acute to subacute appearing left cerebral convexity subdural hematoma without midline shift and non-displaced right occipital skull fracture suggested. R3's prior head CTs dated 12/3/25, 12/26/25, and 12/30/25 do not document a subdural hematoma. R3's Investigative file for R3's rib fractures and pneumothorax, provided by V1 Administrator, included documentation these injuries were reported to the state survey agency and investigated but did not include R3's subdural hematoma or skull fracture. There was no documentation that these injuries were identified, reported and investigated. There is no documentation that R3's 15 minute checks/monitoring continued after R3 returned to the facility on 3/12/26. As of 4/1/26 the Certified Nursing Assistant (CNA) task for 15 minute checks is inactive. R3's Nursing Notes document: On 3/13/2026 at 3:00 AM V5 and V29 CNAs heard a thud from R3's room and found R3 lying on her back on the floor of her room near the sink. There was urine on the floor leading from R3's bed and R3's incontinence brief was on the floor. R3 had a small hematoma on the back of her head. R3 was assisted with toileting needs and back to bed. On 3/13/2026 at 12:59 the IDT identified the root cause of this fall as R3 getting up to use the bathroom in the middle of the night while carrying incontinence brief and intervention was to wake R3 at least once to toilet during the night.R3's Incident Audit Report dated 3/16/26 documents R3 had an unwitnessed fall at 7:15 AM. R3 was found crawling on the floor of her room as V5 walked past to the dining room. R3 had an open area to the left/back side of her head that measured 0.3 cm by 0.2 cm. V5's Statement dated 3/17/26 documents prior to the fall R3 was last toileted at approximately 2:30 AM - 3:00 AM. There is no documentation if R3 was checked on after this, prior to her fall. There is no documentation that a post fall intervention was developed/implemented and care planned for this fall. R3's fall investigations for the above falls, provided by V2 Director of Nursing (DON), do not contain staff interviews or statements that identified the last time R3 was checked on or toileted prior to these falls or R3's activity when last observed. On 3/31/26 at 1:52 PM V5 CNA stated V5 came in at 2:00 AM on 3/13/26 and R3 was last seen around that time in bed sleeping prior to her fall. On 4/2/26 at 12:20 PM in regard to R3's 3/16/26 7:15 AM fall, V5 CNA stated V5 walked past R3's room and saw R3 on her hands and knees near a dining room chair that was in her room and R3 was heading towards her bed. On 4/2/26 at 12:45 PM V15 LPN confirmed R3's unwitnessed fall as documented on 3/13/26. V15 stated there was urine on the floor and thinks R3 was trying to get to the toilet. V15 stated R3 is (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	checked/changed every two hours during the night and usually the last time checked on or changed is documented on the fall investigation forms, as V15 did not specifically remember for this fall. V15 stated the CNAs document 15 minute checks, R3 would stay in bed usually but sometimes she would get restless which would indicate need for toileting. On 4/1/26 at 10:52 AM V2 confirmed R3's 3/13/26 fall investigation does not identify the last time staff observed or toileted R3 prior to the falls. V2 stated R3 was on a standard every two hour toileting schedule prior to adding specific toileting times post falls. V2 stated R3's 15 minute CNA task documentation was not resumed after R3 readmitted to the facility from the hospital, but should have been. V2 stated the cause of R3's rib fractures was determined to be R3 bumping into her sink. V1 Administrator and V2 stated they found out about R3's subdural hematoma and skull fracture upon return from the hospital and thought this was related to a prior fall when R3 had hit her head. V1 stated V1 thought the subdural hematoma was the same one that was previously noted in August 2025. V1 confirmed these injuries were not included in the facility's report to the survey agency or investigated. On 4/1/26 at 2:55 PM V1 confirmed all investigation documentation was provided for R3's injuries/falls.On 4/1/26 at 4:00 PM V2 provided R3's 3/16/26 7:15 AM fall investigation and staff statement. V2 confirmed no documented post fall intervention. V2 stated the intervention was to remove the stationary chair from R3's room. At this time V2 was taken to R3's room where a stationary dining room chair was in R3's room. V2 stated R3's family must have brought the chair into R3's room today when they visited. On 4/2/26 at 10:00 AM V2 confirmed R3's care plan had not been updated with a post fall intervention for this fall. 2.) R1's MDS dated [DATE] documents R1 has moderate cognitive impairment and is dependent on staff for transfers and toileting. R1's Nursing Note dated 2/16/26 at 7:37 PM documents R1 was heard yelling for help and was found sitting on the floor, an unwitnessed fall. On 4/2/26 at 10:13 AM V2 provided R1's fall investigation and confirmed it does not include staff statements/interviews to determine when R1 was last checked on or toileted prior to the fall. V2 stated R1's fall was unwitnessed, R1 was found on the floor by nursing staff and call don't fall signs and encourage use of call light were the post fall interventions. The facility's Elder Justice Act and Reporting Suspected Crimes Against Residents policy dated 10/1/23 documents crimes such as serious bodily injury must be reported to the state survey agency and investigated. The facility's Fall Reduction policy dated 10/30/25 documents the following: The purpose of the policy includes providing an environment that remains as free of accident hazards as possible, identifying residents at risk for falls, developing appropriate interventions, and providing supervision and assistive devices to prevent or minimize fall related injuries. The care plan will indicate for caregivers residents who are high risk for falls and fall interventions, and the care plan will be reviewed and updated after each fall. Falls will be reviewed during the weekly risk management meetings to identify root cause, effectiveness of interventions, and to revise the are plan. The Director of Nursing (DON) or designee shall review the event log on a weekly basis with review of the Quality Assurance Committee to assure the objectives of this policy are being met.