STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0055905	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 10/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNRISE SKILLED NUR & REHAB	333 SOUTH WRIGHTSMAN STREET , VIRDEN, Illinois, 62690

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S0000	Initial Comments Complaint Investigation: Complaint #2636016/2549729	S0000		11/06/2025
S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.1210b) 300.1210c) 300.1210d)6) Section 300.610 Resident Care Policies a) The facility shall have written policies and procedures governing all services provided by the facility. The written policies and procedures shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee, and representatives of nursing and other services in the facility. The policies shall comply with the Act and this Part. The written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, documented by written, signed and dated minutes of the meeting. Section 300.1210 General Requirements for Nursing and Personal Care b) The facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive resident care plan. Adequate and properly supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident.	S9999		11/06/2025

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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S9999	Continued from page 1 c) Each direct care-giving staff shall review and be knowledgeable about his or her residents' respective resident care plan. d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following 6) All necessary precautions shall be taken to assure that the residents' environment remains as free of accident hazards as possible. All nursing personnel shall evaluate residents to see that each resident receives adequate supervision and assistance to prevent accidents. These requirements are not met as evidenced by: 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 10/8/25, documents R2 was originally admitted to the facility on 9/23/19 and was discharged on 7/29/25 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 6/20/25, 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 7/22/25, 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: 7/22/25: (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,	S9999		

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S9999	Continued from page 2 provide/reinforce use of non-skid footwear, 5/20/24 low bed, 5/20/24 mat at bedside, 6/12/20 night light placed in room. It continues R2 Self-Care Deficit as Evidenced by: Needs max to dependent assistance with functional abilities. Interventions: 10/24/23 Bed Mobility - two-person physical assistance required, 7/22/25 Transfer: (full body mechanical lift device) transfer with two assists. R2's Minimum Data Set (MDS), dated 7/16/25, 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 5/29/25, 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 7/21/25. R2's Fall Risk Assessment, dated 6/9/25, documents R2 was a High Fall Risk. R2's Fall Occurrence Note, dated 7/21/25 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: 7/21/25 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 7/21/25, 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	S9999		

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S9999	Continued from page 3 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 7/23/25 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 started complaining of pain to her left leg at that time and Tylenol was given and resident was returned to bed. No noted deformities or bruising noted to the leg. Morphine given at 1250 (12:50 PM) today. Discussed that hospice nurse was going to call him last evening and he reported that she did call and stated that he didn't feel that there was anything to gain by obtaining an X-ray as there is not anything they would do to treat an injury such as a fracture, so he feels that it is best to keep her comfortable at this time. Will monitor and update as needed." R2's Nursing Note, dated 7/23/25 at 3:19 PM, documents "Order received for X-Ray of left hip, left knee, and left femur." R2's X-Ray report, dated 7/24/25, documents R2's x-rays of Left Hip, Pelvis, Left Femur, and Left Knee all showed Negative Fractures. It continues with R2's Pelvis: Examination reveals mild demineralization and degenerative arthritis changes with left hip pinning and flexion deformity of the right hip with follow-up examination of the right hip to adequately evaluate the right femoral neck and no evidence of recent fracture or dislocation. R2's Nursing Note, dated 7/24/25 at 5:24 PM, documents "Resident had x-rays done by (local radiology company) @ (at) 1212 (12:12 PM) of left hip, pelvis, femur, and	S9999		

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S9999	Continued from page 4 knee with no findings of fracture or dislocation noted. Spoke with son (V5) and informed him of findings. Resident seems to be having pain and tugging on left thigh. PRN (as needed) Morphine is being administered as needed. Will fax report to Dr. (doctor) for further advise. Will continue to monitor Resident." R2's Hospice Note, dated 7/29/25 at 3:15 PM, documents "Writer notified by hospice aide of change in resident status, sounds congested and gurgling. writer checked vitals and called hospice nurse requested a call back." R2's Hospice Note, dated 7/29/25 at 5:08 PM, documents "Writer went to assess resident and get new VS (vital signs) and found the resident had passed away. Writer called hospice again to find out why there was no return call from hospice or a visit, and to notify of death. On-call placed a stat (emergent) visit with on-call nurse, writer also informed them to notify family and start calls for notification." R2's Death Certificate, dated 9/15/25, documents R2's cause of death include Pulmonary Thromboembolism, Deep Vein Thrombosis, and Fracture of Right Hip. R2's Autopsy Report, dated 7/30/25, documents in part "Findings: 1. Pulmonary thromboembolism due to deep vein thrombosis as a consequence of fracture of the right hip: A. Thromboemboli occluding branches of the left pulmonary artery. B. Thrombosis of deep veins in the soft tissues of the right hip. C. Pulmonary edema. D. Fracture of the right femoral neck. E. History that the decedent reportedly suffered a ground level fall on July 21st, 2025, while she was being transferred from a wheelchair to her bed. Conclusion: Based on the information available to me, and on the autopsy findings, it is my opinion that (R2), an 84-year-old, white woman, died as a result of pulmonary thromboembolism due to deep vein thrombosis as a consequence of fracture of the right hip. Hypertensive and arteriosclerotic cardiovascular disease is a significant contributing condition." On 10/8/25 at 1:20 PM, V6, Executive Director at (Local Hospice), stated that the Hospice Nurse was not available but documented that R2 had a fall and was complaining of pain to her left leg. V6 stated when the hospice nurse went to assess R2, R2 was sound asleep and when she attempted to put a BP cuff on her, R2 yelped a little, then went back to sleep with VS stable at that time. V6 stated the facility called Hospice to notify them of R2's x-rays which were negative with no	S9999		

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S9999	Continued from page 5 acute fractures seen. V6 stated the hospice nurse did talk to the coroner and tell him that R2 had a recent fall, and the coroner refused to release the body until he got to the facility to assess the situation. On 10/8/25 at 1:42 PM, V7, (Local County) Coroner, stated that the Hospice company flagged him to investigate R2's death because they believed that R2 had a fracture from a recent fall. V7 stated they did an autopsy on R2, and the Pathologist found a right hip fracture on R2. V7 stated R2 was previously x-rayed by an outside company and those x-rays were negative. V7 stated that he believes that R2's Death Certificate showed an accidental death due to complications from a fall. V7 stated usually a hospice person does not get an autopsy, but when he got the heads up on R2 that something was not right, he felt like he had to investigate it further. V7 stated the Pathologist told him that R2's right hip was a new and fresh fracture. On 10/9/25 at 1:50 PM, V15, Physician/Medical Director, stated he took care of R2 up until she was placed on Hospice. V15 stated R2 was on hospice/comfort care only and the goal was to keep her comfortable. V15 stated if the family wanted R2 to be on an anticoagulant (AC) or to have surgery, they could have done so, but her hospice would have been retracted. V15 stated he understands the pathologist findings, however, R2 had several other co-morbidities that he feels contributed to her death, such as severe dementia which could have caused her to fall more. V15 stated he would not have done anything but make her comfortable if he had found out she did indeed fracture her hip during that fall. On 10/9/25 at 2:19 PM, V14, Pathologist, stated he was only advised that they were doing an autopsy on R2 because she had a recent fall, days before her death. V14 stated when he moved R2 over to the autopsy table, that R2's right leg appeared shortened and was rotated outward, and to him appeared to be a fractured hip. V14 stated because of that, he cut open R2's right hip and visibly saw the fractured right femoral neck (hip). V14 stated as he proceeded with the autopsy, he found that R2 had embolisms around her fractured right hip and numerous DVTs of her legs, usually from immobilization. V14 stated he proceeded with R2's lungs and found she had Thromboemboli that were occluding the branches of her left pulmonary artery. V14 stated that it sounds reasonable that R2 could have fallen on her left side, but since that was already pinned from previous fracture, that the force caused her right side to fracture. V14 stated in his professional opinion, R2 was on hospice, a very frail woman, and had a fall with a fractured hip, developed a DVT and a pulmonary	S9999		

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S9999	Continued from page 6 embolism, which all contributed to R2's death. On 10/9/25 at 8:55 AM, V10, CNA, stated "I have taken care of (R2) before and I remember that she was a (full body mechanical lift device) transfer towards the end of her stay here. Before that, she was a two-person transfer assist and would stand and pivot for us. I would not have transferred (R2) by myself, she always needed two people to transfer her." On 10/14/25 at 10:31 AM, V5 (R2's son) confirmed, that should he have been aware that R2 had suffered a right hip fracture, his goal "most likely" would have been for R2 to just remain comfortable and receive pain control in response to her hip fracture. V5 state he had been in contact with hospice service regarding if he wanted R2 to remain under hospice care or seek hospital and additional medical treatment. V5 stated it was decided they would wait and see what the x-rays showed and how R2 was doing, then decide from there. V5 stated he was never given the opportunity to make that choice as R2 expired approximately one week after the fall. On 10/14/25 at 12:57 PM, V18 (Hospice Physician) stated that he was the physician caring for R2 under Hospice care. V18 stated that he believes he was notified of the x-ray results but cannot specifically recall if he personally viewed them as they may have just been sent to the fax machine. V18 stated that if a resident under hospice care suffers a fracture, generally pain management is the treatment of choice. V18 stated that if a fracture is unstable or the resident is experiencing pain that is not resolved with medication, other treatment may be recommended. V18 stated that this would be a treatment plan that would need to be discussed between the resident and/or their representative, along with the hospice team. V18 stated more extensive testing, such as for emboli would not be generally completed under hospice care. V18 stated it should also be noted that decreased mobility a hospice resident can result in embolism formation even without a fracture, although he recognizes a fracture would increase the risk. V18 stated to his knowledge the facility responded appropriately by providing effective pain management to the resident, who remained under hospice care until her death. The Facility's "Fall Prevention Program/Protocol" Policy, dated 9/6/23, documents in part "Purpose is to provide guidance to facility staff regarding the prevention/limitation of falls within the facility. Based on previous evaluations and current data, the staff will identify interventions related to the	S9999		

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S9999	Continued from page 7 resident's specific risks and causes to try to prevent the resident from falling and to try to minimize complications from falling." (A)	S9999		