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 09/04/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
S0000	Initial Comments First revisit to Annual Licensure Certification Survey of 8/14/2025	S0000		09/14/2025
S9999	Final Observations Statement of Licensure Findings 300.610a) 300.1210b) 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. d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour, seven-day-a-week basis: 6) All necessary precautions shall be taken to assure	S9999		09/11/2025

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

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S9999	Continued from page 1 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 were NOT MET as evidenced by: Based on interview, observation, and record review, the facility failed to provide supervision to prevent falls for 1 of 3 residents (R80) reviewed for falls in the sample of 3. Findings include: R80's Admission record, print date of 9/4/25, documents R80 was admitted on 6/27/24 and has diagnoses of mixed receptive expressive language disorder, Hypertension, and Atrial Fibrillation. R80's Minimum Data Set, dated 7/14/25, documents R80 is severely cognitively impaired, is dependent on staff for toileting, dressing, hygiene, sit to stand transfers, chair to chair, chair to bed transfers, is always incontinent of bowel and bladder, and uses a wheelchair. R80's Fall Risk Evaluation, dated 4/8/25, documents that R80 is a high risk for falling. R80's Fall Risk Evaluation, dated 8/29/25, documents that R80 is a high risk for falling. R80's Fall Note, dated 8/21/25 at 12:15 PM, documents, "Incident Description: Resident proceeded to eat lunch and wheeled herself into her room. she tried to transfer herself from her wheelchair to her bed. the resident slid down the front of the wheelchair to her rear end. Fall witnessed by the CNA (Certified Nurse Aide). Resident was not injured and did not hit her head." It continues, Notes: Intervention for this resident was to offer and assist with laying down post meals." R80's Fall Note, dated 8/29/25 at 8:45 AM, documents, "writer heard alarm sounding and entered resident room. Resident was observed laying on her L (left) side with her glasses crooked on her face. Blood noted on the floor. Resident rolled to back herself and blood was seen coming from a skin tear to the bridge of her nose, appears she hit them on her glasses. Writer applied pressure and was able to cleanse area and apply steri strips. ROM (range of motion) assessed with all extremities without an issue. L middle finger is noted	S9999		

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S9999	Continued from page 2 to be slightly bent and a bruise noted to it. No swelling. Resident description: I was going to go lay down. Injuries Observed at Time of Incident. Injury Type Bruise Injury Location left hand (back). Injury Type Bruise Injury Location Face. Injury Type Skin Tear Injury Location Face. Mental Status: Oriented to person. Notes: IDT (Interdisciplinary Team) met to discuss this resident fall. Resident was self-propelling back to room when a staff member heard her alarm sounding and immediately responded." It continues, "Upon further assessment, resident was noted to have bruising to left middle finger. MD and POA aware of results, orders received to send referral to ENT (Ear Nose and Throat Doctor). An intervention for this incident was to place a stop sign on the doorway when resident is out of the room to prevent her from entering room alone and encouraging her to wait for assistance. R80's Fall Occurrence Note, dated 8/29/2025 at 11:22 AM, documents, Incident Description: Resident had an unwitnessed fall with a skin tear to bridge of nose. wound care provided and steri strips applied. Bruising to L(left) finger noted. Xray order obtained for L finger and hand. PRN (as needed) medication administered. Resident statement on what was being attempted when fall occurred Floor was free of spills and no clutter noted. Resident attempting to place self in bed. Resident Description of Fall: I was going to lay in bed. Date/Time of Incident:08/29/2025 8:45 AM. Resident is alert. Residents Orientation: Person. Resident Is Exhibiting Usual Level of Orientation. Injury Observed: Skin tear to bridge of nose, with bruising. L finger is bruised. R80's F/U (follow up) Occurrence Note, dated 8/29/2025 11:55, documents, “Note Text: Note is a follow up to fall today. Facial bruising and swelling noted.” R80’s General Note, dated 8/29/2025 17:28, documents, “Note Text: Xray report received from diagnostics. Shows old fx (fracture)of phalanges no recent fx or dislocation, POA (Power of Attorney) reports she has broken fingers in the past. Nondisplaced fx of the nasal bone noted. MD (Medical Doctor) called and ok with keeping resident at facility. Does have PRN Ultram and PRN Tylenol for pain control. POA called and made aware. Happy with resident being kept and treated at facility. Resident remains alert and pleasant. Nasal swelling noted, does not affect breathing. MD states have a referral sent to ENT for follow up.” R80’s Xray report, dated 8/29/25, documents Nondisplaced fracture of the nasal bone.	S9999		

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S9999	Continued from page 3 On 9/4/25 at 1:05 PM, V2, Director of Nurses, stated, I was the first person on the scene. The fall happened after breakfast. R80 self-propelled herself out of the dining room and went to her room. She said that she was trying to put herself to bed. V2 was questioned if her newest fall intervention from 8/21/25 was to lay R80 down after meals why did that not happened, V2 stated she self - propelled herself to her room and no one saw her leave the dining room. On 9/4/25 at 1:43 PM, V2, Director of Nurses, stated the intervention to lay down after meals came from when she was in an isolation room on 8/21/25. On 8/29/25 she was back in her normal room off of isolation. That intervention should have been removed. I put it in place because she was in isolation. On 9/4/25 at 1:45 PM, V1, Administrator, stated, R80 normally self-propels herself out of the dining room and into her room that is normal for her. No one noticed her leave the dining room. The aides in the dining room were probably helping residents and the aides on the hall were helping residents. On 9/4/25 at 10:26 AM, R80 is lying in bed asleep. R80's face has purple bruising from the eyebrows to the chin. The bridge of R80's nose has a scratch on it. R80's left hand palm side to the wrist has purple bruising and the 3rd finger is purple and swollen. On 9/4/25 at 10:30 AM, R80 stated she does not know what happened. R80 stated her nose hurt. On 9/4/25 at 2:53 PM, V3, CNA, stated R80 likes to lay in bed. She is alert and can tell you what she wants. She has alarms on her bed and wheelchair, a floor mat, a pummel cushion in her wheelchair. She requires a 1 person assist with transfers most days but sometimes two. On 9/4/25 at 2:55 PM, V4, CNA stated R80 can tell you what she wants. She will propel herself in her wheelchair from the dining room to go to her room to go to bed. When we see her do that, we either bring her to the nurses' station and have her sit there so we can watch her, or we put her to bed. R80's Care Plan, Date Initiated: 08/06/2025, documents Resident is at risk for falls r/t (related to) bladder and/or bowel incontinence, functional problems, generalized weakness, impaired cognition with decreased safety awareness, needs assistance with ADLs (activities of daily living). Interventions: bed alarm.	S9999		

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S9999	Continued from page 4 bright tape to call light. Call dont fall sign, for visual reminder. Chair alarm. clear pathways/ environment free from clutter. Dycem under wheelchair cushion and on top of. Maintain call light within reach. Educate resident to use call light. Maintain needed items within reach. Non-Skid Footwear. observe for side effects of meds (medications). pummel cushion. Proper eyewear/clean eyewear Date Initiated: 08/06/2025. Offer and assist resident with laying down post meals. Date initiated: 08/21/25. The fall Prevention Program/ Protocol, dated 9/6/23, documents, “Resident centered Approaches to managing falls and fall risk. 1. The interdisciplinary will implement a resident – centered fall prevention plan to reduce the specific risk factor(s) of falls for each resident at risk (based on the falls assessment results) or with a history of falls” It continues. 5. If falling recurs despite initial interventions, staff will implement additional or different interventions, discontinue ineffective interventions, or indicate why the current approach remains relevant.” "B"	S9999		