STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0047738	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 11/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEECHER MANOR NRSG & REHAB CTR	1201 DIXIE HIGHWAY , BEECHER, Illinois, 60401

(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 Complaint Investigation: 25710699/2658717	S0000		11/21/2025
S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.1210b) 300.1210d)3)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:	S9999		11/21/2025

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

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BEECHER MANOR NRSG & REHAB CTR	**1201 DIXIE HIGHWAY , BEECHER, Illinois, 60401**

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S9999	Continued from page 1 3) Objective observations of changes in a resident's condition, including mental and emotional changes, as a means for analyzing and determining care required and the need for further medical evaluation and treatment shall be made by nursing staff and recorded in the resident's medical record. 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 Regulations are not met as evidenced by: Based on interview, and record review, the facility failed to have safety measures in place to prevent a fall. This failure led to a resident sustaining a 3-centimeter laceration to the left parietal scalp, requiring 3 staples for closure. This applies to 1 of 5 residents (R1) reviewed for falls. The findings include: R1’s electronic health records showed that on 10/22/25, R1 was admitted with diagnoses including a displaced fractured left femur, Parkinson’s disease, and a history of repeated falls. On 11/12/25 at 9:21 am, V5 Certified Nurse’s Assistant (CNA) said that on 10/30/25 around 10 am, she was providing personal hygiene and dressing R1 while R1 was in bed. At this time R1’s upper body was shaking and jerking heavily. V5 said that she had never provided care for R1 before. V5 said she also had not received a report from the off going staff or the nurse on duty about R1. V5 said that she thought that with R1 jerking so heavily that she needed a 2nd staff and a full body mechanical lift. V5 said that she should have done this before she sat R1 on the side of the bed. V5 said she slid R1 to the side of the bed and put her in a sitting position without a 2nd staff assisting. V5 said that she reached for a wipe to clean R1’s face when R1 jerked again and fell off the bed and on to the floor, causing a laceration to her head. R1’s 10/30/25 hospital records showed that R1 had a 3-centimeter laceration to the left parietal scalp requiring 3 staples for closure. On 11/12/25 at 9:52 am, V6 LPN (Licensed Practical Nurse) said that it is the facility’s policy that you	S9999		

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S9999	Continued from page 2 have 2 staff present when putting a resident on the side of the bed prior to transferring them with a sit-to-stand. On 11/12/25 at 5:20 pm, V2 DON (Director of Nursing) said that no staff should put a resident on the side of the bed when the resident is heavily jerking without getting a 2nd staff first. V2 said that if you don't, you are putting the resident at risk of falling. V2 said that her expectations and the facility's practice and policy is always have 2 staff with the sit-to-stand including prior to sitting the resident on the side of the bed. On 11/12/25 at 3:24 pm, V9 (CNA) said that she was V5's partner on 10/30/25 and V5 never asked her to assist her with R1. V9 said that you must have 2 staff present when you put a resident on the side of the bed prior to transferring them with a sit-to-stand mechanical lift. On 11/12/25 at 12:16 pm, V8 (R1's Primary Care Physician) said that R1's fall on 10/30/25 caused a laceration to her head. V8 said that in his professional opinion 2 staff were needed before R1 was placed in a sitting position on the edge of the bed. V8 said that this was important because R1 has Parkinson's, and she was jerking at the time. V8 said that if 2 staff had been there, they could have prevented the fall and laceration. On 11/12/25 at 5:15 pm, V1 (Administrator) said that 2 staff should have been present before putting R1 on the edge of the bed in a sitting position since R1's body had been jerking. V1 said that this should have been done for safety. R1's 10/23/25 – 12/2/2025 Physical Therapy Evaluation & Plan of Treatment showed that R1 is dependent on staff for chair/bed-to-chair transfer. The facility's Fall and Fall Risk, Managing policy dated August 2008, showed that based on previous evaluations and current data the staff will identify interventions related to the resident specific risks and causes to try to prevent the resident from falling and try to minimize complications from falling. Staff will identify and implement relative interventions… to try to minimize serious consequences of falling. R1's 10/22/25 Fall Risk Assessment showed that R1 scored 14 and was categorized as a high risk for falls. The document showed R1 had decreased muscular coordination with contributing factors of neuromuscular/functions and orthopedic conditions. (B)	S9999		