STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 3000624	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 06/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MONMOUTH REHAB AND NURSING	117 SOUTH I STREET , MONMOUTH, Illinois, 61462

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S0000	Initial Comments Facility Reported Incident of 5/6/25/IL193035	S0000		
S9999	Final Observations Statement of Licensure Violations: 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.	S9999		

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

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S9999	Continued from page 1 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 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 observation, interview, and record review, the facility failed to implement appropriate safety interventions for cognitively impaired residents and failed to complete therapy evaluations after multiple falls for two (R1 and R2) of three residents reviewed for falls. These failures resulted in R1 sustaining a left foot fracture and experiencing three falls over a 24-day period, and R2 sustaining a displaced rib fracture and right radial neck fracture following an unwitnessed fall. R2 was later placed on hospice services due to declining condition. Findings include: The facility's Fall Reduction policy revised 11/5/19 documents a therapy screen will be recommended for residents who are at risk of falling. The care plan should be reviewed after every fall and updated with a new intervention. Residents with falls should be reviewed weekly to identify root cause, effectiveness for interventions, and make care plan revisions. 1.) R1's Minimum Data Set MDS dated 3/20/25 documents R1 is cognitively impaired. R1's fall risk assessment dated 5/20/25 documents R1 is high risk for falls. R1's current care plan documents R1 has a diagnosis of Dementia and R1 is at risk for falls due to poor safety awareness. R1 has fallen on 5/6/25, 5/20/25, and 5/30/25. R1's current care plan further documents R1 is independent with transfers, toileting, and mobility in	S9999		

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S9999	Continued from page 2 R1's room. R1's Unwitnessed Fall report dated 5/6/25 at 5:30 AM, documents R1 was found in R1's room sitting on the floor beside R1's bed. R1 was barefoot at the time of the fall. R1 stated R1 slipped trying to get up to go to the bathroom. R1's Nurse Progress Note dated 5/6/25 documents R1 had an x-ray of left foot which revealed a fracture to the head of the fifth metatarsal on left foot. R1 is non-weight bearing to the left foot. R1's Nurse Progress Note dated 5/20/25 documents R1's roommate yelled for help because R1 had fallen out of R1's bed and was on the floor. R1 was sitting on R1's bedroom floor in front of her bed with her legs straight out in front of her. R1's bed was not in lowest position and R1 did not have gripper socks on. R1's room was dark, and her call light was within reach. R1 stated "I just fell out of bed" and "I was trying to go to the bathroom." Fall Intervention is to apply anti slip strips on floor beside R1's bed. R1's Nurse Progress Note dated 5/30/25 documents R1 was seen sitting on the floor by the side of the bed. R1 stated R1 slid off the bed. R1 was sitting with her back supported by the side of the bed and R1's bilateral lower extremities were extended in front of R1. R1 was assisted back to bed by two staff members, R1 was instructed to turn on call light on when wanting to go to bathroom. R1's electronic medical chart does not contain documentation of a therapy evaluation after R1's falls on 5/6/25, 5/20/25, and 5/30/25. On 6/17/25 at 9:30 AM, R1 was lying in R1's bed with R1's eyes closed. Metal half rails were up on the side of the bed. On 6/17/25 at 9:15 AM, V1 (Administrator) stated that R1 is confused and rolled out of bed onto the floor. R1 was inching to the side of the bed and rolled out. R1 had not been evaluated by therapy since admission to the facility.	S9999		

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S9999	Continued from page 3 On 6/17/25 at 10:00 AM, V2 (Director of Nursing) stated R1's falls are usually at night when R1 gets up to go to the bathroom. V2 is unsure when R1 was last screened for a therapy evaluation. V2 further stated that some of R1's safety interventions are not appropriate because R1 takes off R1's gripper socks and will not leave them on. V2 also stated R1 would not remember to use a call light for assistance. V2 confirms R1 does not have very good memory recall especially at night R1 becomes more confused. V2 confirmed R1 should have been evaluated by therapy to ensure it was safe for R1 to be toileting and ambulating in R1's room independently. On 6/17/25 at 9:35 AM, V3 Certified Nursing Assistant (CNA) stated V3 was unaware of R1's fall with a fracture to left foot. R1 gets up on her own and does her own thing in her room. We push R1 in a wheelchair to the dining room because R1 cannot walk very far and R1 is confused and disoriented. On 6/17/25 at 1:31 PM, V6 (R1's Family Member) stated R1 has dementia and was placed in the facility after a fall at home. R1 is unable to care for herself and is very forgetful and does not recognize her family anymore. V6 stated R1 would need help with toileting and ambulating as R1 has had past falls and is very forgetful and unsteady. 2.) On 6/17/25 at 12:50 PM, R2 was lying in bed with eyes closed. R2 was not responsive to voice. R2's family was at the bedside. R2 had half rails on each side of the bed. R2's Fall assessment dated 5/7/25 documents R2 is at moderate risk for falls. On 6/17/25 at 1:00 PM, V6 (R2's Family Member) stated when R2 admitted to the facility approximately four weeks ago R2 was alert and oriented and had been doing things on her own at home. R2 sustained a fall at home and was admitted to the facility for rehab. V6 further stated R2 had a diagnosis of Cancer but had been doing well health wise. V6 stated R2 has fallen approximately four times since being admitted to the facility and has continued to decline each time. V6 stated R2 had an unwitnessed fall on 5/29/25 and sustained a fractured elbow, rib and shoulder. R2 was admitted to hospice after the fall per recommendation of the facility.	S9999		

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S9999	Continued from page 4 There is not enough staff here to provide care, R2's call light doesn't show when it is on at the nurse's station because the panel is broken. V6 further stated V6 regrets bringing R2 to this facility and feels if he had not, R2 would not currently be in the condition she is in. R2's Admission Nurse Progress Note dated 5/7/25 documents R2 was admitted to the facility for therapy. R2 was cognitively intact and required assistance of one staff member and a walker for ambulation and transfers. R2's Social Services Note documents R2 is alert and oriented and was admitted to the facility on 5/7/25 for short term therapy with plans to discharge home after therapy in completed. R2's Nurse Progress Note dated 5/13/25 documents R2 was found on the floor of R2s room crawling on her hands and knees stating R2 thought there was water on the floor coming from the hallway. R2 stated she did hit her head and touched her right-side temple. With the help of staff R2 was helped up and into her wheelchair. R2 was reeducated to use the call light system, location and how and when to use it. R2 was encouraged to call for help when needed. R2 states "I thought there was water all over the floor." R2's Nurse Progress Note dated 5/20/25 documents R2 was observed on her bottom in front of R2's recliner with her knees bent. R2 had a small skin tear on her left elbow. Educated R2 on the importance of calling for assistance when she needs to use the bathroom to ensure her safety so R2 does not fall and harm herself. R2 was helped into her recliner. R2's Nurse Progress Note dated 5/21/25 documents R2 was observed on her hands and knees on the floor looking under her bed. When asked if she needed help R2 stated she was looking for something she had dropped. No signs of injury, R2 is alert and oriented, no abnormalities to head or back or discoloration. R2 was assisted back to bed. R2's Nurse Progress Note dated 5/29/25 documents R2 had an unwitnessed fall and was observed sitting in R2's wheelchair inside her room. R2 apparently was outside	S9999		

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S9999	Continued from page 5 of her room trying to go home. A head-to-toe assessment completed. R2 was able to move all extremities and was unable to raise her right arm all the way but was able to elevate her left all the way up. R2 has large abrasion on her right side back. R2 is complaining of inability to catch her breath although she says it is due to her lung cancer. R2's Nurse Progress Note dated 5/29/25 documents R2 is complaining of pain on right side and right arm from the fall. R2's physician was notified and ordered a mobile x-ray to be performed at the facility. R2's X-Ray results dated 5/30/25 documents R2 has a displaced rib fracture to the eighth rib and a right radial neck fracture. R2's Census documents R2 was admitted to Hospice on 6/1/25. On 6/17/25 at 10:00 AM, V6 (Certified Nursing Assistant) stated when R2 admitted to the facility R2 was alert/oriented and walked with a walker and was an assist of one. R2 was often unsteady and slowly became worse to where two staff had to help R2. R2 was not confused until around the end of May. After R2 fell on 5/29/25 R2 did not get out of bed. (B)	S9999		