STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145470	A. Building B. Wing	04/28/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Heritage Health-Hoopeston	423 North Dixie Highway Hoopeston, IL 60942

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 0689 Level of Harm - 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 interview and record review the facility failed to implement fall interventions to prevent injury for one of three residents (R1) reviewed for falls on the sample list of three. These failures resulted in R1 sustaining a fall which led to a fracture of both the left ulna and left femoral neck. Findings include:The facility's Fall Assessment and Management Policy, revised June 2024, documents the facility will assess each resident's fall risk and implement interventions to decrease the residents' risk of falls and subsequent risk for injury.R1's Medical Diagnosis List, dated April 2026, documents R1's diagnoses including Alzheimer's Disease, Dementia with Agitation, Anxiety, and Chronic Pain.R1's Minimum Data Set, dated [DATE], documents R1 as severely cognitively impaired. R1 is dependent on staff assistance for transfers.R1's Care Plan, dated 7/1/25, documents R1 is at risk for falls related to confusion, and poor safety awareness. An intervention was added on 2/11/25 for staff to assist R1in transferring into his recliner when he is leaning in his wheelchair or appears tired.R1's Nurses Notes, dated 2/26/26, documents R1 was found on the floor, in the dining room, lying on his left side. V3 Registered Nurse documented R1 was lying on the floor in the dining room next to his wheelchair. R1's laptop cushion was sitting next to his wheelchair. R1 often falls asleep in his wheelchair. V3 recommended R1 be transferred to his recliner after meals to rest. At the time R1 did not complain of or show signs of any pain. R1's Interdisciplinary Team Note, dated 3/6/26, documents R1 was sitting in the dining room when staff heard his chair alarm sound. Staff responded and R1 was lying on his left side on the floor next to his wheelchair. R1 is wheelchair bound and needs staff assistance with all transfers. R1 was later sent to the emergency room for decrease in oxygen saturation. At the emergency room R1 was noted to have a fracture of his left wrist.R1's Hospital History and Physical, dated 2/27/26, documents R1 was admitted to the hospital for hypoxia and low-grade fever. During R1's evaluation, R1 complained of left wrist and left hip pain. R1's Left Wrist X-Ray results dated 2/27/26 documents R1 sustained an acute nondisplaced distal shaft fracture of the ulna related to an earlier fall at the facility. R1's Left Hip X-Ray dated 2/27/26 documents R1 also sustained an acute left femoral neck fracture.On 4/28/26 at 12:44 PM V3 Registered Nurse (RN) stated she was R1's nurse on 2/26/26 when he fell from his wheelchair in the dining room. V3 stated it was about shift change at about 2:00 PM when she heard R1's chair alarm sounding and she ran into the dining room to find R1 on the floor beside his wheelchair, lying on his left side. V3 RN stated she completed an assessment the best she could, and he did not complain of pain at the time. V3 stated at the time of the fall, R1 had removed his laptop cushion, which he often does, and fell forward from the wheelchair. V3 stated she had observed R1 prior to the fall, dozing off in his wheelchair in the dining room by the television. V3 confirmed R1 often begins to doze off in the wheelchair and without his laptop cushion he would easily fall forward, as he leans in his wheelchair. V3 confirmed staff should transfer him to his recliner if he is sleepy in his wheelchair to help prevent falls. On 4/28/26 at 3:18 PM V11 Assistant Director of Nurses confirmed R1 often falls asleep in his wheelchair and if staff noticed him doing so on the day of the fall, they should have transferred him into his recliner. V11 confirmed this is an intervention already on R1's Care Plan as a fall intervention and staff need to (continued on next page)

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

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F 0689 Level of Harm - Actual harm Residents Affected - Few	follow resident care plans and always implement fall interventions. V1 confirmed R1 sustained two fractures from the fall.