STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145652	A. Building B. Wing	01/06/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Valley HI Nursing Home	2406 Hartland Road Woodstock, IL 60098

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. Based on observation, interview, and record review the facility failed to ensure fall precautions were updated and in place for residents at risk for falls for 2 of 3 residents (R1, R3) in the sample of 3. This failure resulted in R1 falling and sustaining a head injury.The findings include:The facility's Incident Report dated 1/1/26 shows At approximately 6:49 AM, R1 was screaming for help from her bed and bed alarms were sounding. The Certified Nursing Assistant (CNA) (V5) acknowledged her and the resident states she needed to go to the bathroom. Resident was assisted to the bathroom with her walker and placed on the toilet. R1's call light was turned on and CNA returned to assist resident off the toilet around 7:00 AM. V5 entered bathroom and witnessed R1 lying on the bathroom floor.V5's Resident Incident/Accident Report Employee Statement dated 1/1/26 shows At Around 6:44 AM, I came in to help R1 because she was screaming for help, but she was in bed and then stated she needed to use the bathroom, so I helped her with the walker, put her in there in the toilet. Came back around 7:00 AM, her call light was on less than 3 minutes, and I found her on the floor. V11 CNA was there when I helped her to the toilet at 6:50 AM. This same form shows Residents' behavior prior to accident/incident was marked confused and anxious.V11's (CNA) Resident Incident/Accident Report Employee Statement dated 1/1/26 shows R1 was attempting to use her walker by herself to get to the bathroom instead of waiting for staff. R1 call light was on and V5 went in to assist her to the bathroom. R1 made it but was a little clumsy with the walker. I went to check in with V5 to see if he needed information or help with other residents. He and I went out of R1's room to check on other residents. V8's (CNA) Resident Incident/Accident Report Employee Statement dated 1/1/26 shows R1 was using the bathroom, the CNA left her to go answer another call light while she was still going, that's when someone said she fell.On 1/6/26 at 9:06 AM, V4 CNA Supervisor said R1 uses the call light but if you don't come right away, she calls out and if you don't answer she will try to get up by herself.On 1/6/26 at 9:20 AM, V5 said at 6:50 AM, R1's call light was on, and he went in to assist her to the bathroom. V5 said R1 walked with her walker to the bathroom and after assisting her to the toilet, he left and went to do other stuff. V5 said he came back on the floor and R1's bathroom call light was on. V5 said he found R1 on the bathroom floor on her left side with her head facing the toilet. V5 said he saw blood on R1's head, R1's eyes were closed and R1 was nonresponsive. R1 said he called out for assistance from V4, who went and got the nurse. V5 said he has taken care of R1 before and if you don't answer her call light quickly, she would get up by herself. On 1/6/26 at 10:11 AM, V6 Registered Nurse (RN) said R1 was a big fall risk and had been declining in health quickly recently.On 1/6/26 at 10:50 AM, V8 CNA said she had taken care of R1 the day before and R1 had been losing her balance when transferring her to the toilet with the wheelchair. V8 said she stays close by, right outside bathroom door, when she has R1, who doesn't take long in the bathroom.On 1/6/26 at 11:26 AM, V10 was called, a message was left with no return call.On 1/6/26 at 11:30 AM, V12 RN said she had been giving report on 1/1/26 when she heard that R1 was on the floor in the bathroom. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145652	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/06/2026
NAME OF PROVIDER OR SUPPLIER Valley HI Nursing Home		STREET ADDRESS, CITY, STATE, ZIP CODE 2406 Hartland Road Woodstock, IL 60098	

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	V12 said it was not unusual, R1 was a fall risk and was always falling. V12 said she went into R1's room and saw R1 on the bathroom floor on her left side in the fetal position. V12 said R1 had a small puddle of blood under her head, her lips and hands were cyanotic, and she was dusky looking with agonal breathing. V12 said other staff came in and assisted to get R1 off the floor onto her bed. V12 said once in bed, R1's breathing and heartbeat were not detectable and R1 was pronounced dead by several nurses. On 1/6/26 at 1:28 PM, V14 RN said she had taken care of R1 frequently and R1 had been declining recently. V14 said R1 would be lethargic on days and then would have some good times. V14 said R1 was a fall risk and needed frequent monitoring. V14 said R1 would use the call light but was impulsive. V14 said R1 didn't like to be watched in the bathroom, but staff needed to stay close, in the room when R1 was in the bathroom because she didn't like to wait.On 1/6/26 at 2:07 PM, V10 RN said he was giving report when V4 came to the station and reported that R1 was on the floor. V10 said V5 put R1 in the bathroom and then left he room to check on another resident. V10 said R1's light was on and when V5 went back in, R1 was on the floor in the bathroom. V10 said he assisted the other nurses get R1 into bed and try to obtain vitals. V10 said R1 had a laceration to the left side of her scalp above her left ear. V10 said after multiple attempts, vitals were unable to be obtained, R1's pupils were dilated and fixed, and R1 was pronounced dead. V10 said R1 will not wait for help and will get up by herself if she must wait. On 1/6/26 at 4:25 PM, V16 Hospice RN said she saw R1 on 12/31/25 and noted R1 had increased physical weakness by a noticeable loss of strength when trying to sit up. V16 said R1's impulsivity was till noted during her visit. V16 said R1 was clinically sick and fragile.On 1/6/26 at 1:37 PM, V3 Assistant Director of Nursing said R1 was on hospice and slowly declining. V3 said R1 was a fall risk, and had had previous falls, due to her impulsiveness and getting up by herself. V3 said R1's fall intervention was to be monitored when in bathroom. When asked what that entailed, V3 replied frequent checks. V3 said R1 had previously had a habit of being in the bathroom for long periods of time ripping up toilet paper but had not been doing that recently. V3 said R1's fall interventions for the bathroom had not been updated since R1's recent decline and change in bathroom habit. V3 did not comment when asked how does staff do frequent checks if out in the hall or in another resident's room?On 1/7/26 at 1:18 PM, V17 Medical Director was called, and a message was left for a return call.R1's Client Coordination Notes Report from V16 Hospice Registered Nurse dated 12/31/25 shows No signs/symptoms of imminent death but patient very fragile and generally poor prognosis. Severe tiredness and lethargy. Worsening loss of strength, endurance, and stamina. Patient was arousable today but falls back asleep quickly, reviewed fall/safety precautions. Promote bedrest- Due to constraints of disease process and approaching end of life. Patient needs extensive care with all activities of daily living.R1's Progress notes dated 12/29/25 -12/30/25 document Resident lethargic.R1's Face sheet shows R1 has diagnoses of unspecified dementia, moderate, with other behavioral disturbance and history of falling.R1's Care Plan dated 12/3/25 shows R1 is at risk for falls due to unsteady gait and balance during turns and transitions. Will forget to use walker at times. Intervention dated 3/25/25: Staff to monitor resident while in bathroom and an intervention dated 12/6/18: Observe for gait unsteadiness. Proceed accordingly. The same Care Plan shows 12/2/25 Resident has had a decline in condition resulting in need for hospice care.2. On 1/6/26 at 1:31 PM, R3 was in bed. R3's bed had a bed alarm attached to the bed rail. The bed alarm indicator lights were not on or flashing on and off. V15 Certified Nursing Assistant came into R3's room and said R3 is napping and left the room. This surveyor asked V4 Certified Nursing Assistant Supervisor to check on R3's bed alarm. At 1:34 PM, V4 said the light is supposed to be flashing when the alarm is on. V4 checked R3's bed alarm and held up the cord which was on the floor under R3's bed. V4 said the alarm (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145652	A. Building B. Wing	01/06/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Valley HI Nursing Home	2406 Hartland Road Woodstock, IL 60098

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	is not even plugged in. V4 plugged the bed alarm in, and the bed alarm flashed red on and off indicating the alarm was on. R3's Care Plan dated 4/21/25 shows R3 is a risk for falls related to weakness and unsteady gait and balance. Fall risk assessment score of 16 indicates she is a risk for fall. 12/3/25 resident noted on the floor next to her bed. Intervention: Bed alarm.R3's Physician Orders dated 4/21/25 shows fall prevention/safety: Mobility Alarm: Bed. Special instructions: Ensure that alarm is in place and functioning properly every shift.The facility's Fall Risk Assessment and Prevention Program dated 12/2017 shows The purpose of this policy is to provide direction for nursing home staff to identify residents at risk for falls, to prevent falls whenever possible; and when unable to prevent falls, minimize the extent of the injury. The Care Plan will identify the resident as being at risk for falls. Interventions will be individualized and attempt to modify, or if possible, eliminate risk factors. There will be evidence of care plan review and update following each resident fall to demonstrate that risk factors and interventions remain appropriate for the resident.