

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145721	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/28/2025
NAME OF PROVIDER OR SUPPLIER Villa Health Care East		STREET ADDRESS, CITY, STATE, ZIP CODE 100 Marian Parkway Sherman, IL 62684	

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)
<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40650</p> <p>Based on interview and record review, the facility failed to provide supervision for 1 of 4 (R2) residents, reviewed for falls in a sample of 4. This failure resulted in R2 sustaining a left hip fracture.</p> <p>Findings include:</p> <p>R2's Diagnosis list, dated 1/14/2025, documented diagnoses of high risk for injury related to falls, Dementia, and Lewy Body Dementia.</p> <p>R2's Morse Fall Scale, dated 1/8/2025, documented that she was a high fall risk.</p> <p>R2's Minimum Data Set, dated [DATE], documented that her cognition was severely impaired, that she was occasionally incontinent of urine and that she required substantial to maximum assistance with toilet transfers.</p> <p>R2's Care Plan, dated 1/8/2025, documented, Anticipate and meet the resident's needs. It continues, Be sure my call light is within reach and encourage the resident to use it for assistance as needed. The resident needs prompt response to all requests for assistance.</p> <p>R2's Fall investigation, dated 1/12/2025, documented, Writer summoned to room by CNA. Writer observed pt lying on (Right) side in front of toilet. Resident Description: I tried to get up. Was this incident witnessed: (NO) It continues, Root Cause: Resident new to facility and attempted to walk back to her bed from her toilet without calling for assistance.</p> <p>R2's local hospital history and physical, dated 1/14/2025, documented, [AGE] year old lady who has a known history of dementia was recently admitted to the hospital for (non-s-t elevation myocardial infarction) and pneumonia and was discharged to rehab last week has been doing well in rehab. He (sic) is usually able to take a few steps on Sunday she was trying to walk and has a fall. At that time, she hit her head, and she was complaining of lower back pain yesterday she worked with physical therapy she was able to de (sic) few steps she was hunched over but still was able to do some therapy and this morning she was having difficulty with legs so was brought into the ER she was diagnosed with left hip fracture .</p> <p>(continued on next page)</p>

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
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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>R2's local hospital Xray result, dated 1/14/2025, documented, Findings Mildly displaced intertrochanteric fracture with resultant varus angulation. No pelvic or distal femoral fracture. Impression: Left intertrochanteric fracture.</p> <p>On 1/21/2025 at 2:20 PM, V6, LPN, stated that she knew R2 had a fall history and was a high fall risk. She continued to state that her shift, day shift, did not leave her on the toilet alone because they all knew she was a high fall risk and that there was a white board in R2's room that had written on it that she was a high fall risk.</p> <p>On 1/22/2025 at 9:43 am V7, Licensed Practical Nurse (LPN), stated that she was the nurse who assessed R2 after her fall. V7, stated, The CNA, (V11), came and got me because (R2) was on the floor in the bathroom. She was lying on her right side on the floor. She had a scrape above her right eyebrow and had no complaints of pain. V7 continued to state that she did active and passive range of motion of her legs and arms and there was no issues. V7 stated that she spoke with R2's granddaughter because her power of attorney did not answer the phone. V7 stated that her granddaughter told her that her grandmother falls all the time. V7 was asked, if she knew R2 was a high fall risk and she stated yes and that there was a call don't fall sign in her room and that all rooms have these signs. V7 also stated she did not think R2 knew how to use the call light or what it was for because of her dementia. V7 stated that she did not know why V11, Certified Nurse Assistant (CNA), put her on the toilet and then left the room, maybe to help another resident.</p> <p>On 1/22/2025 at 9:45 am V9, CNA, stated that on 1/14/2025, she went to get R2 up for the day, she assisted her with sitting on the side of her bed, because she wasn't sitting up very well. She was able to transfer R2 into her wheelchair, into the bathroom and on to the toilet with R2 using the assistance bar in the bathroom because R2 was having trouble standing up that day and usually she transferred pretty good. Once R2 was finished using the toilet, V9 stated that she assisted her back into her wheelchair, got her dressed and took her to the dining room for breakfast. V9 stated that R2's appetite was poor that morning, only taking in about 75% of her meal when she usually eats 100%. V9 stated that R2 told her that she was having pain in both of her hips and in her back. V9 stated that she let the nurse know (V10, LPN), they laid her down and (V10, LPN) checked her out. V9 stated that R2 was in pain and had facial grimacing when she transferred her. V9 stated that R2 was a high fall risk but she never tried to get up on her own. V9 stated that she would not leave R2 unattended on the toilet nor would she never depended on R2 using her call light when she needed to get off of the toilet and that she would stay with her until she was finished.</p> <p>On 1/22/2025 at 10:30 am V10, LPN, stated that R2 never asked for pain medication usually but said her hips and back hurts. V10, stated, The CNA (V9) was putting the footrest on (R2's) wheelchair, and her left leg was rotated outwardly, The CNA (V9) and myself, laid (R2) down in bed and I assessed her further. R2's left leg was rotated outward and shortened. I called her doctor for a stat Xray of those areas, and he wanted her sent to the ER immediately. V10 stated that R2 was a high fall risk by just looking at her diagnosis. V10 stated that she told her CNA's who she works with and the oncoming shift not to leave her alone when on the toilet and she should have never been left alone on the toilet. V10 also stated that with R2's dementia she would not know when or how to use the call light.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>On 1/22/2025 at 9:30 AM, V8, Licensed Physical Therapy Assistant, (LPTA), stated that she worked with R2 on 1/13/2025, the day after she fell , she did not complain of any pain. V8 also stated that R2 could not safely transfer herself on or off of the toilet. V8 stated that R2 could hold a call light but did not think she would understand how to use it. V8 stated that from a safety standpoint someone should have stayed in the bathroom with her.</p> <p>On 1/22/2025 at 9:45 am, a phone call was placed, and a message was left for V11, CNA, to return call. V11, did not return phone call.</p> <p>On 1/22/2025 at 11:00 am V2, Director of Nurses, when asked since R2 was a high risk for falls, should she have been left unattended on the toilet? V2 stated no. When asked if a resident, who is a high risk of falls, what type of interventions would be put immediately into place when they are admitted with a history of falls, she stated that some time a bed and chair alarm, and a call don't fall sign. V2 was asked how does the staff know, agency staff included, who is a high risk for falls and interventions? V2 stated that agency should check the residents care plan and also when they get report from the previous shift, they should be let known.</p> <p>An electronic mail document from V12, R2's Physician, containing questions from the state agency and his responses regarding R2's fall, cognition and safety, dated 1/27/2025, documented, 1. Could a fall from the toilet, onto the floor, possibly cause a left hip fracture even though she was found on her right side? Possibly. 2. Do you think that this injury could have been prevented if the facility staff would have stayed with her until she was ready to get off the toilet and not leave her unattended due to her severely impaired cognition and dementia? Yes. 3. Do you think (R2) could understand how to use a call light with her cognition being impaired? Unable to determine at this time.</p> <p>The facility's policy, Subject: Fall Assessment and Management Policy, dated 6/2024, documented, It is the policy of this facility to assess each resident's fall risk on admission, quarterly and with each fall. this will help facilitate an interdisciplinary approach for care planning to appropriately monitor, assess and ultimately reduce injury risk. Factors related to the risk will be addressed and care planned. It continues, D. All staff providing care for the resident will have access to the care plan and/or Kardex.</p>		