STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145721	A. Building B. Wing	07/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Villa Health Care East	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)
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. (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

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(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	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview the facility failed to ensure adequate supervision, and precautions in place for falls for 1 of 3 residents (R2) reviewed for accidents in the sample of 8. This failure resulted in R2 falling off bed fracturing her femur and requiring surgical repair. Findings include: R2's Order Summary Report, undated, documented she had the following diagnoses: unilateral primary osteoarthritis, dependence on wheelchair, muscle weakness, unsteadiness on feet, unspecified lack of coordination, abnormal posture. R2's initial report to Illinois Department of Public Health (IDPH) dated 6/24/2025 documents R2 slid off the bed on 6/23/2025 at 8:00AM. The report documented CNA (Certified Nurse's Assistant) was assisting (R2) with her morning cares including dressing, personal hygiene, and transferring her from her bed to her wheelchair. (R2) was sitting up on the side of her bed and slide off the mattress onto the floor on her left side. The report documented Interventions put into place to ensure that resident has 'gripper socks' on at all times while in bed. R2's X-ray report dated 6/24/2025 at 11:51AM documents R2 presented to the emergency room after a fall this morning. R2's x ray report documents distal femoral shaft fracture.R2's orthopedic report dated 6/25/2025 documents R2 requires surgery of left femur.R2's Fall Risk assessment dated [DATE] documents R2 is a high risk for falls. R2's fall risk assessment documents a score of 60. (High risk 46 or greater). R2's fall risk assessment documents R2 has fallen before and has impaired gait.R2's Minimum Data Set (MDS) dated [DATE] documents R2 is cognitively intact with a Brief Interview Mental Status (BIMS) of 14. R2's MDS documents selfcare- 2 needed some help - resident needed partial assistance from another person to complete any activities. R2's MDS documents R2 has impairment of lower extremities on both sides. R2's MDS documents R2 is dependent on staff for toileting hygiene, showers, transfers from bed to a chair or wheelchair. The MDS documented regarding the ability to move from sitting on side of bed to lying flat on bed and the ability to move from lying on the back to sitting on the side of the bed with no back support R2 required substantial/maximal assistance. R2's Care Plan, revised 6/8/2025 documents R2 has an Activity of Daily living (ADL) selfcare performance deficit related to gait balance problems, CKD (chronic kidney disease), muscle weakness, diabetes, HTN (hypertension), CAD (coronary artery disease). R2's care plan documents the following interventions: 6/9/2025 transfer: R2 requires dependent staff assist times 2 with a mechanical lift with transfers.R2's Care Plan, dated 7/1/2025 documents R2 is a high risk for falls related to (r/t) Gait/balance problems, CKD, muscle weakness, diabetes, HTN, CAD. R2's care plan documents the following interventions: 6/26/2025 will continue to work with therapy as ordered, 4/30/2025 Anticipate and meet the resident's needs, 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, educate me/family/caregivers about safety reminders and what to do if a fall occurs, follow facility fall protocol, my family has transferred me from one surface to another. Educate them and I that this is not safe and that all transfers should be done with staff only, Pt evaluate and treat as ordered or PRN. R2's Care Plan failed to document gripper socks as documented in fall investigation to ensure gripper socks in place.V7's, Certified Nurse's Assistant, CNA, witness statement dated 6/24/2025 documents V7 left R2 sitting on side of bed while V7 left the room to get the sit to stand lift. The statement documented I was assisting (R2) in bed to get ready for the day. I sat her on the side of the bed to empty out her (indwelling catheter) (and) to assist w (with) getting up. I was told she uses the sit to stand to get up. I left her sitting on the side of the bed because her feet were touching the ground, and she was holding onto the bed. When I came back in from getting the sit to stand (I was only out of the room for 15 secs (seconds) as it was right outside the room) (R2) was sliding down, kinda like she assisted herself to the ground.On 7/14/2025 at11:03AM, R2 stated she was a sit to stand transfer prior to breaking her femur. R2 stated she was sitting on side of bed and CNA left room to get the lift and was just getting back in room and turned to get sling, R2 stated she told CNA she was falling.On 7/16/2025 at 1:51PM, V1, Administrator, stated fall interventions are to be in place after each fall. V1 stated she would expect care plan to document all fall interventions.On 7/16/2025 at 1:55PM V2, Director Of Nursing (DON) stated R2 is a high fall risk and should not be left sitting on bedside. The Facility's Fall policy, revised 6/2024, documents it is the policy of the 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