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	10/15/2025

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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews, observations, and record reviews the facility failed to implement and revise resident care plans after resident falls for 4 out of 7 residents (R2, R3, R4 and R7); reviewed for Resident Care Plans in a sample of 7. Findings include:1. R2's Face sheet documented she was admitted to the facility on [DATE] with diagnosis of, in part, urinary tract infection, cerebral infarction, hemiplegia and hemiparesis on right dominant side, repeated falls, laceration of scalp, dementia, and lack of coordination. R2's Minimum Data Set (MDS) dated [DATE] documented she was moderately cognitively impaired and required substantial/maximal assistance from staff for toileting hygiene and going from a sitting position to a standing position (which means the helper does more than half the effort, lifts or holds trunk or limbs). R2's MDS continued to document she required partial/moderate assistance with toilet transfers. R2's Care Plan last revised on 4/10/25 documented she was at risk falls related to gait/balance problems, poor communication/comprehension and psychoactive drug use. R2's fall risk care plan continued to document the following interventions, in part, I am a high fall risk and must not be left alone in the bathroom or sitting on the side of the bed (date initiated 7/21/2025), physical therapy/occupational therapy to evaluate (date initiated 7/23/2025), anticipate and meet the resident's needs (date initiated 1/20/2025), ensure R2's recliner alarm is in place, turned on and working properly (date initiated 8/14/2025), increase visual rounding (date initiated 9/11/2025), staff needs to remain with me in the bathroom as I try to do things for myself and fall (date initiated 9/26/2025). R2's Incident Audit Reports documented she fell on the following dates 7/16/25, 7/19/25, 8/26/25, 9/1/25, and 9/24/25. R2's Fall Risk Care Plan was not updated after her falls dated 7/16/25 and 8/26/25. 2.R4's Face Sheet documented he was admitted to the facility on [DATE] with diagnosis of, in part, dementia, aphasia, and lack of coordination.R4's MDS dated [DATE] documented he was severely cognitively impaired and required partial/moderate assistance from staff for all transfers. (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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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R4's Care Plan initiated on 7/16/25 documented he was a high risk for falls related to deconditioning, gait/balance problems, dementia, history of seizures, diabetes, osteoarthritis. Interventions included on R4's Fall Risk Care Plan included the following, in part, to ensure bed alarm is in place, turned on and working properly (Date Initiated: 7/16/2025), ensure chair alarm is in place, turned on and working properly (Date Initiated: 7/16/2025), ensure that the resident is wearing appropriate footwear (non-skid socks) when ambulating or mobilizing in w/c (Date Initiated: 7/16/2025), and to follow facility fall protocol (Date Initiated: 7/16/2025). R4's Incident Audit Reports documented he fell on the following dates 7/30/25, 8/11/25, 8/19/25, 8/21/25 and 9/3/25. R4's Care Plan was not updated after his falls occurring on 8/11/25 and 8/19/25. R4's Incident Audit Report dated 8/21/25 documented it was noted that R4 had his own socks on, which were slick and not the socks with treads. The facility's Grievance form dated 9/15/25 documented, Family would like bed alarms on bed, w/c (wheelchair) and recliner at all times. He went to see physician yesterday and did not have w/c alarm. The form continued to document bed and chair alarms are care planned for this resident; recommendations/action taken were to ensure bed and chair alarms are on and in place. 3.R7's Face Sheet documented she was admitted to the facility on [DATE] with diagnosis of, in part, pneumonia, atrial fibrillation and heart failure. R7's MDS dated [DATE] documented she was cognitively intact, uses a wheelchair and required supervision or touching assistance from staff for going from a sitting position to standing. R7's Care Plan revised on 7/7/25 documented she was at risk for falls with the following interventions, in part, do not leave R7 unattended while in the bathroom or while sitting on the side of the bed and anticipate and meet her needs. On 10/14/25 at 10:55 AM, R7 stated the staff pays no attention to preventing falls, she doesn't get any assistance to the restroom and does most things on her own. On 10/14/25 at 11:40 AM, V10 (Medical Director) stated a resident showing urinary tract infection symptoms and a change in mental status would be at an increased risk for falls. V10 stated he would expect staff to put in place fall precautions if a resident's mental status declined. V10 stated he would expect staff to be following the resident's care plan. On 10/14/25 at 1:30 PM, in a joint interview with V1 (Administrator) and V2 (Director of Nursing), both stated they would expect the care plans to be followed. 4. R3's Face Sheet, dated 10/14/2025, documented a diagnosis of Periprosthetic Fracture around internal Prosthetic Left Hip Joint and Alzheimer's Disease. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R3's Incident Audit Report, dated 7/26/2025 at 9:42 PM, documented, Writer and CNA at desk and heard a loud scream. Resident noted to be on floor on left side on bottom and head against wall when writer walked in room. V2, Dir of Nurses documented the Root cause analysis as Resident turned around to fast while leaving her bathroom and lost her balance. Fall Management Review document back dated for 7/28/2025 at 11:36:00 on 8/3/2025 11:41:48 documented, Background: Resident ambulates using her walker and transfers with assist of 1. Resident forgets to use her call light at times. It continues, Recommendations: Reeducated on using call light for assistance. R3's Care Plan, dated 7/25/2025, documented, I am a high fall risk. Do NOT leave me unattended while in the bathroom or while sitting on the side of the bed. But there was not an intervention put in place after R3's fall on 7/26/2025. The facility's policy, Care Plan Process, dated 11/2017, All plans of care must be reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly assessment. The facility's policy, Fall Assessment and Management, dated 6/2024, documented, C. Care planning after a fall: 1. A licensed nurse will consult with the resident's care givers and other interdisciplinary team members in regard to future intervention, and resident specific risk factors. 2. Potential environmental hazards will be reported to the Environmental Services Department.

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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 observation, interview and record review, the facility failed to supervise 2 of 4 (R2 and R3) residents, reviewed for accidents in a sample of 7. This failure resulted in R3 sustaining a left hip fracture. R2 sustaining a right frontal laceration to her head. Both incidents resulted in hospitalization.Findings include: 1.On 10/14/2025 at 9:07 AM, R3 was sitting on the side of her bed, 1 foot on the floor and the other dangling off the bed and the bed was not in the lowest position. No staff were in the room. The bed alarm was underneath the bed pad but was not sounding. R3 was barefoot. R3's call light was on the nightstand out of R3's reach. On 10/14/2025 at 9:07 AM, R3 stated that the night she fell and broke her hip she went to the bathroom, on her own and when she reached to get the soap she fell, landing on her butt. R3 was asked if she used her call light to call for help, she laughed and did not answer. On 10/9/2025 at 10:06 AM, V4, Licensed Practical Nurse (LPN), stated that she was R3's nurse the night she fell, but this was the 1st time working R3's hallway. V4 stated that in report that night she was told that R3 transfers on her own with her walker, did not complain of any pain and that R3's baseline was confusion, but she was also told in report that R3 needed help of 1 staff person for supervision. V4 continued to state that she was on the other side of the hall, and the CNA came and told her that R3 was on the floor. She continued to state that R3 complained of back pain but when they rolled her over, to assess her back, she complained of left hip pain, and they gently rolled her back and called 911. When asked about if a staff member was with R3 when she fell or when she went to the bathroom and V4 stated she did not know. On 10/9/2025 at 11:00 AM, V5, Certified Nurse Assistant (CNA), stated that the night that R3 fell, she was the only CNA for that hallway and that is usually the normal staffing for that hall. She continued to state that she has been with the facility for 14 years and has been R3's CNA, at night, since she was admitted . She stated that R3 was ambulatory with her walker, but she was unsteady because she had a urinary tract infection. V5 stated that night she was in another resident's room, assisting them, and heard someone yell and then a loud noise, she left that room immediately and found R3 sitting on her butt on the floor in the bathroom. She stated that she told her do not move and that she was getting the nurse. She went and got the nurse and that the resident denied pain and the nurse told her she was going to be sent out to the ER. When asked, about if R3 required supervision for ambulation and going to the bathroom, she stated yes but R3 never uses her call light or calls for help. V5 stated that R3 was not supposed to get up by herself but she will not call for help nor will she use her call light, but this was how R3 has always been since her admission to the facility. On 10/14/2025 at 11:42 AM, V10, R3's Primary MD, stated that he does not know if increased staff on the night R3 fell would have prevented her fall, but the facility knew she was not going to use her call light. V10 stated that he would expect the facility to follow R3's care plan interventions they had in place. R3's Face Sheet, dated 10/14/2025, documented a diagnosis of Periprosthetic Fracture around internal Prosthetic Left Hip Joint and Alzheimer's Disease. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	R3's Progress note, dated 10/4/2025, documented, 0025 CNA notified this nurse that she observed resident on the floor in her bathroom after hearing a loud crash. This nurse went to assess resident and noted resident to be on the floor flat in the bathroom. This nurse asked resident what happened in which resident stated to this nurse that she was in the bathroom using the bathroom when she went to stand up and got dizzy and fell on her bottom. This nurse asked resident if she was in pain and resident stated to this nurse her back was hurting her. Upon assessment no bruising, bleeding, skin tear/ open areas noted. Resident v/s at the time of incident 149/85, 77hr, 18resp, 99oxygen. This nurse attempted to notify (Power of attorney) and noted phone to be going to (voice mail). This nurse attempted to notify Dr. and received message that there was an application error which was inhibiting the phone call to go through. This nurse attempted to notify on call management for the facility and reached (voice mail). 911 called resident transferred to (local) hospital. Report passed to (Emergency Department) nurse. R3's History and Physical for local hospital, dated 10/4/2025, documented, Impression/Plan Ground level fall Left femur periprosthetic fracture . It continues, History of Present Illness: [AGE] year-old woman with above-mentioned medical problems is brought to the ER from assisted living facility for evaluation after she had a fall. Patient reports that she lives in assisted living facility and went to the bathroom. After she got up, she felt dizzy and fell down without loss of consciousness or head trauma. She called for help and then EMS was called by the staff in the assisted living facility. She is found to have left femur periprosthetic fracture. Her main complaint is acute on chronic low back pain. She does not express any pain in the left hip. R3's CT scan, dated 10/4/2025, documented, IMPRESSION: Postsurgical changes of prior left femoral rodding with findings concerning for loosening. Superimposed infectious process is not excluded. Recommend clinical correlation. There is fracture of the proximal left femoral rodding. R3's Morse fall risk scale, dated 8/19/2025, documented that R3 was at a moderate risk of falling. R3's Fall Risk assessment, dated 5/13/2025, documented that she was at a high risk of falling. R3's Care plan, dated 7/25/2025, documented, I am a high fall risk. Do NOT leave me unattended while in the bathroom or while sitting on the side of the bed. It continued to document, 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. R3's Minimum Data Set (MDS), dated [DATE], documented, that her cognition was moderately impaired, no impairment of upper or lower extremities and that she used a walker for ambulation. She required supervision or touching assistance for Chair/bed-to-chair transfer: The ability to transfer to and from a bed to a chair (or wheelchair), Toilet transfer: The ability to get on and off a toilet or commode and going from sitting to standing: The ability to come to a standing position from sitting in a chair, wheelchair, or on the side of the bed. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	R3's Incident Audit Report, dated 10/4/2025 documented, Nursing Description: This nurse notified by CNA that resident had fallen in bathroom after assessing resident this nurse noted resident to be expressing pain in her left hip during assessment. Resident Description: Resident stated to this nurse she had taken herself to the bathroom because she didn't want to wait to be taken and when she went to stand up from the toilet, she got dizzy and fell. Resident stated to this nurse she had taken herself to the bathroom because she didn't want to wait on to be taken and when she went to stand up from the toilet, she got dizzy and fell. It continues, Factors: Confused and Current UTI. Predisposing Situational: Ambulating without assist and Using Wheeled walker. 2.R2's Face sheet documented she was admitted to the facility on [DATE] with diagnosis of, in part, urinary tract infection, cerebral infarction, hemiplegia and hemiparesis on right dominant side, repeated falls, laceration of scalp, dementia, and lack of coordination. R2's Minimum Data Set (MDS) dated [DATE] documented she was moderately cognitively impaired and required substantial/maximal assistance from staff for toileting hygiene and going from a sitting position to a standing position (which meant the helper does more than half the effort, lifts or holds trunk or limbs). R2's MDS continued to document she required partial/moderate assistance with toilet transfers. R2's Care Plan last revised on 4/10/25 documented she was at risk falls related to gait/balance problems, poor communication/comprehension and psychoactive drug use. R2's fall risk care plan continued to document the following interventions, in part, I am a high fall risk and must not be left alone in the bathroom or sitting on the side of the bed (date initiated 7/21/2025), physical therapy/occupational therapy to evaluate (date initiated 7/23/2025), anticipate and meet the resident's needs (date initiated 1/20/2025), ensure R2's recliner alarm is in place, turned on and working properly (date initiated 8/14/2025), increase visual rounding (date initiated 9/11/2025), staff needs to remain with me in the bathroom as I try to do things for myself and fall (date initiated 9/26/2025). R2's Fall Risk Assessments completed post falls were dated 7/19/25, 8/26/25, 9/1/25, and 9/25/25 all rating her high fall risk. R2's Incident Audit Reports documented she fell on the following dates 7/16/25, 7/19/25, 8/26/25, 9/1/25, and 9/24/25. R2's Incident Audit Report dated 7/16/25 documented the root cause of her fall was that she accidentally put her electric lift chair into the standing position which caused her to slide to the floor. R2's Incident Audit Report dated 7/19/25 documented the writer ran into R2's room after hearing R3 yell out, help she fell, and I can't help her up. The report continued to document the root cause of her fall was that she bent over to get briefs off the floor of her closet and fell on her bottom. R2's Incident Audit Report dated 8/26/25 documented the writer and another registered nurse ran to room as R2's roommate (R3) yelled out, She needs help in here. The report continued to document R2's roommate, R3, stated she was walking from the bathroom to the chair and grabbed onto the wall before falling. The report documented R2 was transferring herself without assist, she was looking for something in her closet, R2 forgets limitations and has had a recent age-related decline in mobility and cognition. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	R2's Progress note dated 8/26/25 documented Remind resident to use call light before ambulating. Make sure chair alarm is in place and out of reach of resident before leaving the room each time. R2's Incident Audit Report dated 9/1/25 documented R2 was found on the bathroom floor by the CNA in front of the toilet in a seated position. The report continued to document R2 was transferring herself to the bathroom without assist, she has to go to the bathroom and forgets limitations and recent age-related decline in mobility and cognition. R2's Progress note dated 9/1/25 documented, Recommend CNA or nurse to stay with patient while she is on the toilet, since she overestimates her abilities and does not always call for assistance. Recommend frequent reminders to patient that she always needs to call for assistance rather than attempting to do things on her own. R2's Progress note dated 9/5/25 documented, Recommend that resident room be moved closer to nurses station for enhanced observations and quicker response. POA (Power of Attorney) refuses for resident's room to be switch because resident has settled into that room and does not want to change things. R2's Progress note dated 9/10/25 documented, Resident experiencing increased urinary frequency. Urine is dark yellow and cloudy and foul smelling. Order for UA (urinary analysis) and CS (culture and sensitivity) received. Collect tomorrow night to be picked up Friday by lab. R2's Progress note dated 9/17/25 documented, Writer reached out to Doctors office regarding numerous unsuccessful attempts at getting urine sample for UA. Resident refusing straight catheterization to obtain sample. Writer discussed resident's recent change in behavior. Order for CBC (complete blood cell) and BMP (Basic Metabolic Panel) received and to be drawn Friday 9/19/2025. R2's Incident Audit Report dated 9/24/25 documented R2 was on the toilet and while given privacy to have a bowel movement R2 attempted to clean herself and fell off the toilet landing on her left side and hit her head. The report continued to document there was blood noted on her head, left arm and on the floor. The report continued documenting R2 was conscious the whole time and 911 was called with pressure applied to the wounds. R2's Hospital Records dated 9/25/25 documented R2 had a fall and was treated for a right frontal laceration that was repaired with 5 absorbable sutures. R2's Hospital Discharge summary dated [DATE] documented R2 was admitted to the hospital for a fall, urinary tract infection, altered mental status, and wound of sacral region. R2 was discharged on bacitracin topical ointment and cefdinir oral antibiotic. R2's Progress note dated 9/26/25 documented, Writer spoke with residents daughter who voiced concern with residents falls. Writer explained to daughter that the CNA was in the bathroom with the resident who tried to wipe herself and fell forward off of the toilet. Resident didn't want the CNA to wipe her as she wanted to do it herself. Moving forward staff will remain present and assist resident with personal hygiene as needed and as resident allows. Explained to daughter that the resident did have rights and we cannot force her to allow staff to wipe her. However, staff will again remain in the bathroom with her at all times while the resident is in there. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	R2's Progress note dated 9/26/25 documented, Resident sent to hospital r/t (related to) fall right forehead laceration and received 5 absorbable laceration 3 cm (centimeter) X (by) 0.5 cm. Resident also has UTI (urinary tract infection) and is currently taking ABX (antibiotics). On 10/9/25 at 11:05 AM, V5 (CNA) stated R2 is a high fall risk, she used to turn her bed and chair alarms off so they would have to hide the box from her but now after she came back from the hospital from her last fall she stays in bed. V5 stated she takes care of R2 on the night shift and she typically doesn't get up. V5 stated if R2's alarms are in place, she will hear them if she triggers it. V5 stated she walks the halls constantly checking in on the residents and assisting with needs as needed to prevent falls. V5 stated when she notices a resident is unsteady on their feet or having difficulties with tasks, she will constantly check on them. V5 stated R2 always has her call light in reach but rarely uses it. V5 stated after a resident falls, she doesn't move them, goes to get a nurse, they will assess the resident and then will either call 911 or transfer the resident to the bed or chair with a full body mechanical lift. V5 stated we find out updates on interventions in reports each shift. On 10/9/25 at 11:40 AM, V7 (CNA) stated R2 would frequently get up to go to the bathroom without calling for help. V7 stated R2's hall has a lot of confused residents at risk for falls. V7 stated after 2:00 PM they only have 1 CNA for 23 residents now and they really need 2, it's hard to keep up. On 10/9/25 at 11:42 AM, V6 LPN stated her main concern for R2 is falling. V6 stated she does regular checks on her and makes sure her alarms are on. V6 stated there is only 1 nurse working from 10:00 PM to 6:00 AM with 3 CNAs. V6 stated R2 was always getting up to go to the restroom without calling for help but now she has a urinary catheter and doesn't get out of bed. V6 stated after a fall occurs, they document, go over new interventions and the care plan. V6 stated new updates on falls are discussed during daily shift reports. V6 stated falls are always a concern. On 10/14/25 at 11:40 AM, V10 (Medical Director) stated a resident showing urinary tract infection symptoms or a change in mental status would be at an increased risk for falls and he would expect staff to put in place fall precautions. V10 stated he would expect staff to be following the resident's care plan. On 10/14/25 at 1:30 PM, in a joint interview with V1 (Administrator) and V2 (Director of Nursing), V2 stated she would expect to be notified of a significant change. V1 and V2 stated it is the resident's right to have privacy. V1 and V2 both stated they would expect the care plans to be followed. The facility's Falls 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. The policy continued to document each resident will be assessed using the MDS upon admission, quarterly and with any significant change assessment. The potential for falls will be care planned when appropriate, based on the results of the Fall Risk Assessment. The Interdisciplinary care plan will be person centered to reflect the specific needs and risk factors of the resident.

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, facility failed to have sufficient nursing staff to assure resident safety and care for 4 of 7 (R3, R5, R6 and R7) residents reviewed for staffing. This failure has the potential to affect all 96 residents residing in the facility. Findings include:1.R3's Progress note, dated 10/4/2025, documented, 0025 CNA notified this nurse that she observed resident on the floor in her bathroom after hearing a loud crash. This nurse went to assess resident and noted resident to be on the floor flat in the bathroom. This nurse asked resident what happened in which resident stated to this nurse that she was in the bathroom using the bathroom when she went to stand up and got dizzy and fell on her bottom. This nurse asked resident if she was in pain and resident stated to this nurse her back was hurting her. Upon assessment no bruising, bleeding, skin tear/ open areas noted. Resident v/s at the time of incident 149/85, 77hr, 18resp, 99oxygen. This nurse attempted to notify (Power of attorney) and noted phone to be going to (voice mail). This nurse attempted to notify Dr. and received message that there was an application error which was inhibiting the phone call to go through. This nurse attempted to notify on call management for the facility and reached (voice mail). 911 called resident transferred to (local) hospital. Report passed to (Emergency Department) nurse. R3's Minimum Data Set (MDS), dated [DATE], documented, that her cognition was moderately impaired, no impairment of upper or lower extremities and that she used a walker for ambulation. She required supervision or touching assistance for activities of daily living. R3's Care Plan, dated 7/25/2025, documented, 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. It continues, I am a high fall risk. Do NOT leave me unattended while in the bathroom or while sitting on the side of the bed. 2. On 10/14/2025 at 10:50 AM, R6 stated that there was not enough help on the night shift and that usually it is just 1 nurse and 1 CNA and that both shifts could use more help. R6, MDS, dated [DATE], documented that her cognition was intact, that she was dependent upon staff for transfers and mobility. 3. On 10/14/25 at 10:50 AM, R5 stated the facility hardly has any nurses, they need more. R5's Face sheet documented she was admitted to the facility on [DATE] with diagnosis of, in part, atrial fibrillation, heart failure and unsteadiness on feet. R5's MDS dated [DATE] documented she was cognitively intact. R5's Care Plan revised on 4/10/25 documented she was at risk for falls. 4. On 10/14/25 at 10:55 AM, R7 stated in the evening and night, there is only 1 CNA and there needs to be more. R7 stated she does not get rounded on every 2 hours. (continued on next page)

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	10/15/2025

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.

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	R7 Face sheet documented she was admitted to the facility on [DATE] with diagnosis of, in part, pneumonia, atrial fibrillation and heart failure. R7's MDS dated [DATE] documented she was cognitively intact, uses a wheelchair and required supervision or touching assistance from staff for going from a sitting position to standing. R7's Care Plan revised on 7/7/25 documented she was at risk for falls with the following interventions, in part, do not leave R7 unattended while in the bathroom or while sitting on the side of the bed and anticipate and meet her needs. On 10/9/2025 at 10:06 AM, V4, Licensed Practical Nurse (LPN) stated she was the only nurse working the night of 10/4/ 2025 and she had 3 hallways to take care of. On 10/9/2025 at 11:00 AM, V5, Certified Nursing Assistant (CNA), stated that the night that R3 fell, she was the only CNA for that hallway and that is usually the normal staffing for that hall. On 10/14/2025 at 12:30 PM, V9, Scheduler, stated that there are 3 shifts that she schedules for but nurses and CNA's work 12-hour shifts. V9 stated that V1, Administrator and V2, Director of Nurses, but mainly V2, will tell her how many CNA's and Nurses to schedule for each shift. She continued to state that she schedules 10 CNA's and 5 nurses for day shift and 7 CNA's and 2 Nurses for the night shift and that at night 1 nurse is on one side of the building with 2 halls, and the other is on the other side, and they would have 3 halls. The nurse that has the 2 halls has a total of 4 CNA's and the other 3 halls has a CNA on each hall to take care of residents. On 10/9/25 at 11:40 AM, V7 (CNA) R2's hall has a lot of confused residents at risk for falls. V7 stated after 2:00 PM they only have one CNA for 23 residents now and they really need two, it's hard to keep up. On 10/9/25 at 11:42 AM, V6 (LPN) stated there is only one nurse working from 10:00 PM to 6:00 AM with three CNAs for this side of the building. On 10/14/2025 at 1:45 PM, V1, Administrator, stated that they do not have policy for staffing the facility with nursing staff, but they follow the CMS minimum staffing rules and their facility assessment. Reviewed staff assignment sheets for 7/29/2025, 7/30/2025,9/24/2025, 10/3/2025, and 10/4/2025 all documented that on these dates from 6:00 PM to 6:00 AM, there was 1 nurse and 1 CNA for the hall where R2, R3, R4, R5, R6 and R7 reside. The facility's Grievance Form dated 8/18/25 documented, CNAs need to be checking on the residents every 2 hours to make sure needs are being met. Resident council meeting minutes dated 8/18/2025 documented Call lights are not being answered in a timely manner- all shifts/all hallways. It continues, Skilled unit- CNA's need to check on residents at least every two hours to make sure needs are being met. (continued on next page)

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	145721	A. Building B. Wing	10/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	The Facility Assessment Tool, dated 01/2024 through 12/2024, documented, Staffing plan 4.2. Based on your resident population and their needs for care and support, describe your general approach to staffing to ensure that you have sufficient staff to meet the needs of the residents at any given time. Examples of two different ways to look at your staffing plan are provided in the tables below. Choose a methodology that works best for your organization. You may elect to use one or both tables below or choose your own methodology. It may be helpful to review specific staffing references in the regulation regarding the facility assessment (483.71). For a discussion on how to determine sufficient staffing, see Appendix 2 Section 7.b. Our facility regularly evaluates staffing, equipment, infrastructure, and services to ensure we effectively meet resident needs while maintaining regulatory compliance and financial stability. We remain committed to continuous quality improvement to enhance resident safety, care quality, and operational efficiency. Staffing calculations we follow: 1. Determine the number of residents needing skilled care. 2. Multiply the number of skilled care residents by 3.8 hours per resident per day. 3. Add the total number of hours needed for each level of care. 4. Multiply the total number of hours by 25% to get the minimum number of licensed nurse hours. 5. Multiply the total number of hours by 10% to get the minimum number of registered nurse hours. It continues, Direct care staff Refer to CMS Minimum staffing rule: 8-9 CNA on day shift, 7 CNA on evening shift, 7 CNA on night shift. The facility's Centers for Medicare and Medicaid Services, dated 10/08/2025, documented that there were 96 residents that reside in the facility.