

Illinois State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0046821		(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, Illinois, 60098			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE	
S0000	Initial Comments		S0000			01/20/2026	
	Incident Report Investigation Survey #2706602 for 1/1/26						
S9999	Final Observations		S9999			01/20/2026	
	Statement of Licensure Violations:						
	300.610a)						
	300.1210a)						
	300.1210b)						
	300.1210d)6)						
	Section 300.610 Resident Care Policies						
	a) The facility shall have written policies and procedures governing all services provided by the facility. The written policies and procedures shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee, and representatives of nursing and other services in the facility. The policies shall comply with the Act and this Part. The written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, documented by written, signed and dated minutes of the meeting.						
	Section 300.1210 General Requirements for Nursing and Personal Care						
	a) Comprehensive Resident Care Plan. A facility, with the participation of the resident and the resident's guardian or representative, as applicable, must develop and implement a comprehensive care plan for each resident that includes measurable objectives and timetables to meet the resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment, which allow the resident to attain or maintain the highest						

Office of Primary Care and Health Systems Management

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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S9999	Continued from page 1 practicable level of independent functioning, and provide for discharge planning to the least restrictive setting based on the resident's care needs. The assessment shall be developed with the active participation of the resident and the resident's guardian or representative, as applicable. (Section 3-202.2a of the Act) b) The facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive resident care plan. Adequate and properly supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident. d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour, seven-day-a-week basis: 6) All necessary precautions shall be taken to assure that the residents' environment remains as free of accident hazards as possible. All nursing personnel shall evaluate residents to see that each resident receives adequate supervision and assistance to prevent accidents. These regulations were not met as evidence by: 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. 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		S9999				

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S9999	Continued from page 2 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.		S9999				

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S9999	Continued from page 3 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. 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 the 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		S9999				

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S9999	Continued from page 4 "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 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		S9999				

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S9999	Continued from page 5 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." (A)		S9999				