STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146029	A. Building B. Wing	08/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Franciscan Village	1270 Franciscan Drive Lemont, IL 60439

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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure safe transfer mobility for a resident who is dependent on staff for transfer assistance. This failure resulted to R118 falling from her wheelchair and sustaining fracture injury. In addition, the facility also failed to follow recommended transfer assistance and appropriate use of assistive devices for residents who are identified as high-risk for falls. This applies to 4 of 4 residents (R10, R43, R52, R118) reviewed for accidents and supervision in the sample of 19.The findings include:1. R118’s face sheet showed that R118 was admitted to the facility on [DATE], with diagnosis that included urinary tract infection, toxic encephalopathy, personal history of transient ischemic attack with cerebral infarction, cognitive communication deficit, rheumatoid arthritis, unsteadiness on feet, and lack of coordination. R118’s Minimum Data Set, dated [DATE] showed R118 had lower extremity impairment on the left side and is dependent on staff for transfers and mobility. Dependent means helper does all of the effort R118’s progress notes dated August 12, 2025 and written by V24 (Registered Nurse) showed the following: At around 12:50 PM writer answered call light to assist resident to the bed. While transferring the resident to the bed the resident lost her balance in the wheelchair and fell on her side. The resident hit her head on a small cabinet. No bleeding or injury noted. Provider notified with no new orders given. The facility’s incident report dated August 16, 2025 showed the following: R118 had diagnoses that included toxic encephalopathy, cerebral infarction with affected left side. R118 was alert and oriented to self, and time and required a 2 person assist with transfers. On August 12, 2025, R118 was being transferred by the registered nurse when R118 lost her balance, fell, and hit her head on a cabinet. On August 14, 2025, R118 was noted to have left hip pain and was guarding during positioning. The provider was notified and an x-ray of R118’s left hip was ordered. R118’s x-ray results of her hip showed a fracture and R118 was sent to the emergency room for evaluation and treatment. “Conclusion: education for registered nurse provided for proper transfer of patients. Documented coaching given to the registered nurse, and all staff to be in-serviced on proper resident transfers.” R118’s x -ray results ordered on August 14, 2025 showed a fracture of the left femoral neck with displacement of the distal fragment. On August 20, 2025, at 1:19PM, V24 (Registered Nurse) stated that around 12:50PM on August 12, 2025, V24 was passing medications when R118’s call light went on. V24 answered the call and asked (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 0689 Level of Harm - Actual harm Residents Affected - Few	R118 if she would like to get into bed. V24 asked R118 if she was able to stand up and assist V24 with repositioning the wheelchair. V24 stated she began to reposition the wheelchair when she stopped the wheelchair it was facing the bed and R118 slid out of the chair. R118 slid onto her left side hitting her head and shoulder on the dresser and then landing on the floor. V24 stated that R118 had left sided weakness and required two staff members for transfers. V24 noted three family members were present in room at time of incident. V24 stated she told the resident not to move then she left the room and found V25 (Certified Nursing Assistant) in hallway and asked for assistance with resident. On August 20, 2025, at 2:02PM, V32 (Family Member 1) stated that R118’s left leg has not been functional since her stroke, and her left leg tends to curl inward behind right leg. V32 stated that R118’s left leg needs to be well positioned before movement. V32 stated that R118 was complaining of pain in groin and leg on Wednesday, Thursday, and Friday. On August 20, 2025, at 2:30PM, V33 (family member) stated she was in the room at the time of R118’s fall. V33 stated that around 11:15 AM on August 12, 2025. V33 stated that R118 was sitting up in a wheelchair and R118 wanted to go back to bed. V24 came to R118 room and said she would come back after meal to assist R118 back to bed. V24 walked in and asked R118 If I help you stand will you be able to get into bed. V33 told V24 that R118 has not been walking, is post stroke, and has left sided weakness. V33 stated V24 did not respond. V33 stated she told V24 multiple times that R118 has left side weakness. V33 stated V24 started to move wheelchair into position to near the bed. When V24 started moving the wheelchair back and she lifted and turned it at the same time to angle it into position. V33 said screamed in pain and V24 said pick your legs up. V33 was tried to explain that R118 cannot pick her leg up but V24 did not acknowledge it. R118's left leg was dragging and it got stuck behind her the right leg. R118 was leaning towards her left side. When V24 lifted the back of the chair to help turn it more, R118 fell out of the chair, hitting her head and shoulder on the table and landed on the ground on her left side. On August 21, 2025, at 2:10 PM, V35 (Family member) stated that he visited R118 on August 12, 2025, along with two other family members. V24 came in and gave R118 some medications and came back later to assist R118 into bed. V24 began moving objects in room to assist prepare for transfer. V35 stated the family began to inform V24 that R118 is unable to walk. V24 started to turn wheelchair, and he noticed that R118 legs were not moving with the wheelchair. V35 stated it happened really fast when V24 continued to move R118, V24 lifted the back of the wheelchair. The lifting the back of the wheelchair caused R118 to hit her head and shoulder on the dresser as she fell to the ground. On August 20, 2025, at 4:09 PM, V3 (Assistant Director of Nursing) was notified by V24 on 08/12/2025 regarding incident with R118. V3 stated that an order for an x-ray of the left hip was obtained on August 15, 2025, when a nurse noted R118 reported new onset guarding to left leg. V3 stated the family requested ice packs during this time. The facility was later notified of R118’s acute fracture. V3 stated that if residents hit their head during a fall the nurse on duty performs neuro-checks, pain assessments, fall assessments and ROM (Range of Motion) exercises. An investigation was completed with nurses and CNAs. The day of the incident V3 was called to the room by V24. According to V3, there were family members present in the room when the resident fell. V3 stated repositioning R118 in the wheelchair would require two staff assistance. V3 stated Incident reports are completed immediately, and a morning meeting is held the next day discuss interventions. In this instance a meeting was held the next day and the intervention was to perform staff education. V3 stated V24 had attempted to transfer resident alone. V3 stated that R118 had left sided weakness. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	On August 20, 2025 at 11:06 AM, V26 (Nurse Practitioner) stated that she just happened to look through R118’s medical record on August 15, 2025 and noticed that R118 x-ray results showed a fracture. V26 called the facility and told them to send R118 out to hospital. V26 stated that the fracture was a result of the fall. V26 said R118 could not stand up on her own. The expectation is that the provider is notified right away in instances of head injuries. With a head injury the patient would need to go out to the hospital for a evaluation. V26 stated she nor the doctor were aware that R118 hit her head during the fall. V26 stated that had the provider’s been aware of the head injury they would have sent R118 to the emergency room immediately. R118’s care plan dated August 11, 2025 showed R118 was at risk for falls due to decreased mobility, weakness, left sided weakness and had ADL (Activities of Daily Living) self-care and mobility deficit. R118’s fall care plan showed the following intervention dated August 12, 2025: Re-educate staff related to transfer status. R118 was seen by physical therapy and occupational therapy between August 12, 2025, an August 15, 2025. Therapy progress notes showed R118 required maximum assistance for transfers and bed mobility. R118’s 72 hour post fall monitor dated August 14, 2025 at 3:47 PM showed the following: R118 “verbalized pain on left hip, guarding during positioning.” R118’s progress note dated August 14, 2025 at 10:59 PM showed the following: Resident complained of left hip pain and guarding her side during positioning. The doctor was notified and gave an order for a left hip x-ray to rule-out fracture. R118’s had and order dated August 14, 2025 at 10:44 PM for an X-ray of the left hip. 2. Face sheet shows that R52 is 93 years-old who has multiple medical diagnoses including dementia, generalized muscle weakness, unsteadiness on feet, lack of coordination, and repeated falls. On August 18, 2025, at 11:33 AM, R52 was in the dining room eating lunch, sitting on her wheelchair, she had a wound on her forehead that was almost healed. A staff member stated that R32 fell 2 to 3 weeks ago. On August 19, 2025, at 12:59 PM, V19 (Certified Nursing Assistant/CNA) assisted R52 in the bathroom for toileting. R52 was assisted to stand and pivot for transfer from wheelchair to toilet seat. After R52 voided, V19 assisted R52 to stand up and instructed R52 to stay still while V19 provided peri-care. Afterwards V19 assisted R52 back to the wheelchair. This process was all done without using a gait belt. R52's Morse Fall Scale dated May 28, 2025, shows R52 is high risk for fall. R52's Minimum Data Sheet (MDS) dated [DATE], shows R52 is cognitively impaired and dependent with sit to stand position and toilet transfer care. Fall incident log and progress notes from April to August 2025 showed that R52 has history of multiple fall incidents. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	R52’s active care plan shows she is at risk/active for falls. R52 has altered safety awareness. R52 overestimates her abilities related to previous CVA (cerebrovascular accident), history of falls, decrease balance/mobility/ADL skills. Decrease cognitive function and decrease thought process due to dementia. This same care plan shows multiple interventions including two staff assistance with use of gait belt for transfers. 3. Face sheet shows that R43 is 97 years-old with multiple medical diagnoses including vascular dementia, poly-osteoarthritis, generalized muscle weakness, history of fall, history of fracture of unspecified part of neck of right femur, subsequent encounter for closed fracture with routine healing. On August 19, 2025, at 1:25 PM, V20 and V21 (Both CNA) transferred R43 from reclining wheelchair to bed via mechanical lift. R43 was positioned in the middle lower half of the sling with the lower part of her buttocks and lower extremities off the sling and not supported. R43 was screaming that her back was hurting. V21 stated the sling was sliding while she was in the reclining chair. V20 placed her arms under R43’s legs during transfer, while R43 was screaming all throughout that her back was hurting. 4. Face sheet shows R10 is R100 years-old who has multiple medical diagnoses including spinal stenosis, generalized muscle weakness, lack of coordination, and unspecified dementia. On August 20, 2025, around 12:20 PM, V23 and V29 (Both CAN) transferred R10 from bed to wheelchair using a gait belt. R10 appeared afraid and hesitant to transfer. R10's knees were bent/folded and was not fully standing. There was no non-skid wheelchair pad on her wheelchair seat. R10 Morse Fall Scale dated 8/13/25 shows, R10 is a high risk for fall. Facility's fall log from February to August 2025 shows that R10 has had multiple fall incidents. R10's Fall Care Plan shows: R10 is at risk/actual falls related to diagnoses of orthostatic hypotension, history of falls, incontinence, muscle weakness, joint stiffness, and dementia. This same care plan shows interventions which include ensuring non-skid mat on the wheelchair seat. On August 20, 2025, at 3:36 PM, V2 (Director of Nursing/DON) stated that staff must follow all fall prevention interventions especially for residents who are identified as high-risk for fall. Ensure that staff use assistive device as recommended to prevent fall incidents.