STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145724	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Addolorata Villa	555 McHenry Road Wheeling, IL 60090

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. 41156 Based on interview and record review, the facility failed to prevent an incident of resident to resident physical aggression. This affected two of three residents (R1, R2) reviewed for physical abuse. This failure resulted in R2 kicking R1 in the leg and R1 sustaining a 7 cm skin tear. Findings Include: Facility Reported Incident reviewed, and reads in part: On 9/2/24 at 2:20PM, R1 was in the common area when R1 began talking in a loud voice at a R3 who was trying to push a table over. R2 approached R1 while R1 was speaking to the R3 and kicked R1 in the left lower leg, resulting in a skin tear. R1 has a diagnosis of Dementia and Restlessness and Agitation. R1's most recent BIMs score conducted on 8/16/2024 was 03/15 indicating severe impairment. R1 has diagnosis of Dementia, R1 exhibits poor safety awareness and poor impulse control. R1 also has a care planned behavior of becoming verbally agitated, which has caused peers to become agitated. R2 has a diagnosis of Dementia and Generalized Anxiety Disorder. R2's most recent BIMs score conducted on 07/02/2024 was 03/15 indicating severe impairment. R2 has a care planned behavior of exhibiting poor impulse control as well as having difficulty with interpreting her environment related to her Dementia. After thorough investigation of residents and staff, it was determined that due to R1's behavior of speaking in a loud manner at R3, R2 was frustrated with R1 and wanted R1 to stop talking and because R2 exhibits poor impulse control related to R2's advanced dementia R2 kicked R1 in response. Both residents were immediately separated and R1's skin tear to R1's left lower leg was immediately treated. On 9/28/24 at 11:40AM, V3 (Nurse on 9/2/24) stated that someone yelled to V3 to come over here, R2 kicked R1 and R1 was bleeding. V3 went and R1 was in the wheelchair located in the common area in front of the nurse's station, noted bleeding on the lower leg. V6 (RN) put pressure on the area of the wound. R1 was wearing short pants, and I could see the lower leg. Noted on left lower leg, shin area has a skin tear over 7cm in size, bleeding continuously. V6 and V3 brought R1 by the treatment cart. R2 was separated from R1, R2 was in the west corridor area after the incident. (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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NAME OF PROVIDER OR SUPPLIER Addolorata Villa		STREET ADDRESS, CITY, STATE, ZIP CODE 555 McHenry Road Wheeling, IL 60090	

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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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 9/28/24 at V4 (CNA) stated V4 was passing by the common area, observed R3 shaking the table, R1 was behind R3 and telling R3 stop doing this, stop it. Stop it. R1 was saying this loud, R1 is hard of hearing, and R1 always talks loud. Suddenly I saw R2 propelling R2's wheelchair towards R1. As R2 was heading to R1, R2 was not saying anything at all. And then suddenly, V4 just passed the common area when V4 heard R1 yelling, She kicked me, she kicked me. And as V4 returned to the common area, V4 saw R2 propelling back close to the window, R2's usual spot. V4 went to check on R1 and then saw blood on R1's leg. V4 removed R1 out of the common area, V4 told the nurse and then 2 nurses assisted with R1's wound. On 9/28/24 at 1:25PM, V6 (RN) stated that V6 was in the nurse's station charting and monitoring R3 in the common area because they are high risk for fall. V6 stated that the common area is right across from the nurse's station. R2 was sitting next to the window. R1 was sitting in the middle of the common area, closer to R3. R3 was trying to move the table, making sounds, and R1 started to talking to him, saying Stop doing it, what are you doing. R1 always talks loud due to being hard of hearing. V6 stated that R2 was sitting in her wheelchair by the window, saying stop yelling too much to R1 and at this time R3 stopped moving the table. V6 stated she did not see R2 head towards R1 because there was a center wide pole wall blocking V6's visual to R2 from where V6 was at the nurse's station, charting. V6 just heard R1 say she kicked me. R2 was closer to R1 at the time. On 9/28/24 at 3PM, V2 (DON) stated that on 9/2/24 the incident was reported by the nurse on the floor. It was reported by the nurse that R2 had kicked R1 in the shin. My question was were they immediately separated? Then the nurse said that V4 (CNA) had taken R2 away and V3 (RN) provided treatment to R1. The facility investigated the incident, and the outcome of the investigation was that both residents have dementia. R1 is hard of hearing and spoke with a deeper louder voice at R3 who was banging on the table. R2 approached R1 and R2 got frustrated with R1. R2 told R1 to stop talking and because of the advance dementia that R2 has, R2 kicked R1 in response because R2 exhibits poor impulse control. It is not uncommon for R2 to propel themself and wanders the unit, and the staff did not anticipate R2 kicking R1. On 9/29/24 at 9:40AM, V9 (Activity Aide) stated that R2 did not attend activity that day. V9 said they have never seen in 10 months that they have been working in the facility that R2 is with any physical aggression; but, has observed R2 at times with verbal aggression towards others, such as staff and residents. R2 would get upset, and based on my own experience, R2 got upset when I was trying remove R2 from the dining room. R2 shouted at me and said, leave me alone, and cursed at me. R1's progress notes dated 9/2/24 at 1520, reads in part: R1 got skin tear on LLE (7cm length) and a little bleeding with surround (sic) hematoma, which was kicked by one of residents (R2) in common area at 2:20PM. Immediately, applied steri-strips after normal saline cleansing with Bacitracin ointment on the site. Then applied Foam dressing. Elevated her LLE on the sofa, also applied ice pack for the pain and hematoma. Await MD's s response. The POA aware. Informed DON as well. Endorsed next shift. Behavior notes for R2 dated 9/2/24 at 1432, reads in part: R2 kicked one of residents at 2:20PM, who got skin tear on LLE with bleeding in common area. R2 was separated from the resident at that time as well. Called her POA, the MD and DON aware. Behavior note for R2 dated 8/7/24 at 1304, reads in part: R2 was yelling and fighting with the other resident for moving sofa. R2 almost hit the resident by left hand. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Behavior notes for R2 dated 7/18/23, reads in part: At 8:30PM, three residents R1and R2 are convincing another resident to stay seated because the resident keeps walking and wandering without her walker for so many times. R2 was trying to stop R1 from following another female resident. This female resident getting agitated and verbally rude to R1, R2 feels bad and did not like how this resident treated R1. R2 became impatient or annoyed with the female resident and pushed her walker while standing in front of her causing this female resident to fall on the floor. RN asked why R2 did that, R2 said because she is mean to R1. Staff separated the residents from each other to prevent further harm. Redirected as needed. R2's care plan for Behavior dated 9/4/24 stated R2 exhibits poor impulse control and confusion r/t her Dementia. R2 becomes easily agitated and has difficulty interpreting the environment around her. R2 has attempted to hit staff members as well as peers. Abuse, Neglect and Exploitation policy with a revised date of 1/1/24, reads in part: Franciscan Ministries affirms that each resident has the right to be free from abuse, neglect, misappropriation of resident property and exploitation. Resident must not be subjected to abuse by anyone, including but not limited to community staff, other residents, consultants, contractor, volunteers, or staff of the other agencies serving the resident, family members, legal guardians, friends, or other individuals. Physical abuse includes, but is not limited to hitting, slapping, punching, and kicking. It also includes controlling behavior through corporal punishment.