

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  12/22/2024
NAME OF PROVIDER OR SUPPLIER  Addolorata Villa		STREET ADDRESS, CITY, STATE, ZIP CODE  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)		
<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41692</b></p> <p>Based on interview and record review, the facility failed to implement a physician's order for an as soon as possible (STAT) X-ray after one resident (R1) sustained an unwitnessed fall and complained of pain in the right hip area; and the facility failed to document in the medical record after one resident (R1) sustained an unwitnessed fall. This failure affected one resident (R1) who was transferred to a local emergency room ten hours after the unwitnessed fall took place and was diagnosed with a right hip fracture.</p> <p>Findings include:</p> <p>R1 is a [AGE] year-old male originally admitted on [DATE] with medical diagnoses that include and are not limited to: dementia without behavioral disturbances, chronic obstructive pulmonary disease, and hypertension. According to the Minimum Data Set (MDS) R1 had a brief interview for mental status (BIMS) dated: 9-26-2024 with a score of 5/15, which indicate impaired cognition.</p> <p>On 12-21-2024 at 2:40 pm V10 (Certified Nurse Assistant) said, on 10-27-2024 I went to R1's room since the call light was pulled. R4 (R1's roommate) pulled the call light and said, I called for help because I heard a noise, I think R1 had a fall. I saw R1 on the floor, R1 was facing the bathroom door on his right side, R1 said he was having pain I think in his right hip and leg area. I immediately called for the nurse, V14 (Nurse) came to see R1, assessed the patient, and told us V11 and V10 (Certified Nurse Assistants) that we could move the patient to the wheelchair. I put the gait belt on R1's waist and we moved R1 to the wheelchair and took him to the toilet then we placed him in his bed, and the nurse told us the doctor ordered an x-ray of the right hip and leg area.</p> <p>On 12-21-2024 at 11:15 am V2 (Director of Nursing) said, V14 is on personal time off outside of the country and unable to be reached. According to my investigation, R1 had a fall on 10-27-2024 at 9:30 pm, V14 contacted V15 (Medical Doctor) at 10:40 pm and received an order for an X-ray of the right hip to be completed as soon as possible (STAT). The X-ray was not taken, and the portable X-ray company never came to the facility. My expectation for a STAT x-ray is 4-6 hours. R1 was sent to a local hospital on 10-28-2024 at 7:40 am (ten hours after the unwitnessed fall). R1's fall assessment dated : 10-18-2024 reads a score of 75- indicating a high risk for falls. R1's care plan reads: anticipate R1's needs, assist when he needs to go to the bathroom, call light within reach, (we do not have any assessment to confirm the ability of the patient to use the call light), remind R1 to ask for assistance and bed in low position. I am not able to find any documentation in R1's medical record for the fall dated 10-27-2024. My expectation is for the documentation to be in the resident's medical record. It is not acceptable that V14 did not complete the documentation.</p> <p>(continued on next page)</p>		

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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID:  145724	Facility ID:  145724  If continuation sheet Page 1 of 3

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 12-21-2024 at 11:10 AM V1 (Administrator) said, we have a risk management form completed by V14, it is an internal document that I am not able to share with IDPH.</p> <p>On 12-21-2024 at 2:00 pm V12 (Registered Nurse) said, R1 had a fall on the 3-11 shift. I worked on the 11-7 shift. R1 complained of pain in the right hip, the MD ordered a STAT x-ray, the x-ray company told me that they could not come to do it during the night shift, I told V2 (Director of Nursing). I did not report to the doctor. I documented the vital signs, but I did not document the pulse oximetry, I do not remember if took it or not. I should have done it. I know I have to do neurological (neuro) checks. On 10-28-2024 at 5:00 am R1 was provided incontinence care, R1 complained of pain in the right hip.</p> <p>On 12-21-2024 at 2:50 pm V12 said, I should have called the doctor to let him know the delay on the STAT x-ray and obtain further orders. I need to remember to complete the neuro checks after an unwitnessed fall, I am sorry, it was my fault.</p> <p>On 12-21-2024 at 12:55 pm V7 (Registered Nurse) said, R1 was able to walk using the rolling walker with one person's assistance and the wheelchair the rest of the time, able to feed himself after the tray was set up. R1 was alert and oriented to self and confused. R1 was not able to use the call light, R1 will get anxious very easily and will not have an understanding of his physical limitations. I kept him by the nurse station all the time for people to keep an eye on him since he was a high risk for falls. I do remember on Monday, 10-28-2024 I was working during the first shift, I did my rounds to make sure the patients were doing well when I took reports from the night nurse. R1 was in his bed, I saw that R1 was having labored breathing and difficulty to aroused, his right hip was noted to be red, and R1 complained of pain. I did a pulse oximetry (pulse Ox) and the machine read 66%, according to EMR (electronic medical records) Vitals Blood Pressure 125/65 T 97.7 Heart rate 88 Respirations 26. I increased the oxygen to 10 liters via mask I called the doctor and I sent R1 via 911. V12 (Registered Nurse) from the night shift, said the right hip x-ray was not done because the company was not able to come during the night. We nurses, need to take a full set of vital signs including blood pressure, heart rate, temperature respiratory rate, and oxygen saturation, we need to complete the neurological (neuro)checks to make sure the patient is not having any changes in condition. The neuro checks are done: every 15 min for the first hour, then every 30 min x 2, every hour x 4, and every 8 hours for the remaining time to complete the 72 hours.</p> <p>On 12-21-2024 at 12:20 pm V4 (Registered Nurse) said, when any of my patients have an unwitnessed fall, I am responsible for making sure to evaluate the patient, we are not to move the patient if there is any complaint of pain, we must call 911 as a nursing intervention. I will complete a head-to-toe assessment, if the patient is complaining of hip, or leg pain the nurse needs to make sure the extremities are not having any shortening. I need to take a full set of vital signs including blood pressure, heart rate, temperature respiratory rate, and oxygen saturation, we need to complete the neurological (neuro)checks to make sure the patient is not having any changes in condition. The neuro checks are done: every 15 min for the first hour, then every 30 min x 2, every hour x 4, and every 8 hours for the remaining time. The nurse is responsible for notifying the medical provider: Nurse practitioner or medical doctor and the Director of Nursing if any of the provider's orders cannot be followed.</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 12-21-2024 at 12:45 pm V6 (Registered Nurse) said, R1 was confused and forgetful. We as nurses need to make sure to follow the doctor's orders and if we are not able to carry the order out, we need to call and report to the doctor for any further orders. If the patient has an unwitnessed fall, we need to make sure to complete a complete body assessment and start neuro checks, that is the only way to see if the patient is having any change in condition. Neuro check if I remember correctly needs to be done every 15 min for the first hour, then every 30 min x 2, every hour x 4, and every 8 hours.</p> <p>On 12-21-2024 at 1:40 pm V3 (MDS Coordinator) said, if the patient has an unwitnessed fall, the nurse must start neuro checks, complete the fall, and pain assessments, call the medical doctor, and update the care plan. The neuro checks are done to make sure the patient does not have any changes in their mental status. The nurse needs to document in the electronic medical record any changes in condition, falls, incidents, and any monitoring. R1 was a nice patient, very forgetful and unable to use the call light consistently due to his cognitive status.</p> <p>R1's hospital records read: primary diagnosis on 10-28-2024 at 8:03 am Acute and Chronic respiratory failure with hypoxia. X-ray of pelvis dated: 10-28-2024 at 10:59 am indicated pain in the right hip, trauma. findings: there is a fracture through the right lesser trochanter and lucency through the intertrochanteric portion of the hip.</p> <p>Orthopedic note dated: 10-28-2024 at 5:07 pm reads: right lower extremity is externally rotated, mild swelling of the hip and proximal leg.</p> <p>On 12-21-2024 at 3:10 pm V15 (Primary Medical Doctor) said, my expectation is for the nurse at the long-term care facility to call me when a STAT X-ray is not done. I need to be called when I give an order and is not able to be completed. I was never notified that the STAT X-ray was not done for R1. R1 was a very complex patient, he had cardiac and respiratory issues among many other issues.</p> <p>On 12-22-2024 at 5:20 pm V2 (Director of Nursing) said, my expectation for the nurse to document in the medical records when the patient has any falls, to notify the medical provider, to document in the patient's medical record if any new order is received and carried out. The standard of practice requires the nurse to communicate with the doctor if the order is not carried out. It is unacceptable not to have complete medical record including and not limited to when the patient has a fall. The nurse is responsible to take a full set of vital signs and to monitor the patient's condition. We do not have any policy on neurological checks, we do not have any policy on carrying out doctors' orders.</p> <p>V2 presented a policy dated: 3-21-2024 and titled: documentation in medical records reads: documentation shall be completed at the time of service, but no later than the shift in which the assessment, observation, or care service occurred.</p>		