

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 08/14/2025
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)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. (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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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record reviews the facility failed to follow their policy and procedures for abuse prevention by not reporting an allegation of abuse for a resident with a history of making abuse allegations. This failure applies to one of four residents (R1) reviewed for abuse. Findings include: R1 is a [AGE] year-old female with a diagnosis's history of Dementia with Behavioral Disturbance, Chronic Venous Hypertension with Ulcers of Right and Left Lower Extremities, Stage 3 Chronic Kidney Disease, Hypothyroidism, and Recurrent Severe Major Depressive Disorder who was admitted to the facility 05/04/2025. R1's Behavior Progress Note dated 5/21/2025 documents a CNA (Certified Nursing Assistant) informed that R1 went to the bathroom by herself, urine was all over the floor in the bathroom, R1 was then brought to common area and said, The lady abused me. I'm gonna call V7 (Family Member). The facility did not have an abuse investigation report for R1's abuse allegation from 05/21/2025. On 08/13/2025 at 1:34 PM V1 (Administrator) stated if she was aware of any abuse related concerns for R1 she would have addressed them, but she was not aware of these issues for R1. On 08/13/2025 1:53 PM V2 (Director of Nursing) stated R1 had a history of making allegations prior to admission towards caregivers and families, doesn't know if the documentation regarding R1 stating the lady abused me, would be considered an allegation, doesn't know what the writer meant. R1 has impaired cognition this would not change that an allegation was made but may affect V2's perception of what happened, this allegation would still have to be investigated if V2 were made aware of it, this should have been reported to the administrator, if the nurse would have informed V1 or V2 that R1 stated someone abused her V2 would have notified the administrator. If something is reported or seen in the community, we immediately report it to our administrator. The proper protocol would have been followed if she or V1 would have been notified about the allegations of abuse from R1. On 08/14/2025 from 10:26 AM - 11:30 AM V1 (Administrator) stated they spoke to the nurse and aide involved with caring for R1 on 05/21 and the nurse made the clinical decision to document the comment about being abused and wanting to call V7 (Family Member) from R1 to demonstrate her psychiatric behavior in conjunction with other behaviors displayed during that time, and quoted this because the nurse was just attempting to document paranoid and delusional behavior; what we have done for R1 is have multiple care plans in place based on three care plan meetings since she arrived to the facility and have been documenting on her behaviors of paranoia and delusions and consulted with psychiatry to coordinate her care. V1 stated V6 (Certified Nursing Assistant) was the staff being accused by R1 of abusing her on 05/21 and was the aide working with R1 during that time. V6 had informed the nurse that R1 went in the bathroom alone and when V6 went in there to monitor her, R1 didn't want her there and became upset when V6 stated she was there because she didn't want her to slip and fall. When V6 brought R1 out to the common area R1 made the abuse accusation and V6 told V4 (Registered Nurse) what happened and knew that R1 was upset with her for intervening in R1's care. V6 reported to the nurse that there was urine on the floor, and she was assisting R1 because she was engaging in behavior that wasn't safe. On 08/14/2025 12:52 PM V1 (Administrator) stated she followed up with V4 (Registered Nurse) and V4 doesn't recall or remember anyone else being in the room with V6 (Certified Nursing Assistant) on 05/21 when she was caring for R1. When asked by the surveyor how it can be determined R1's report of abuse by V6 occurred if there were no witnesses V1 replied by V6 coming forward and reporting what happened that's how V4 (Registered Nurse) made her judgment that R1's report of abuse was a psychiatric behavior not an allegation of abuse. The facility's Abuse, Neglect and Exploitation Policy received 08/14/2025 states: Franciscan Communities affirms that each resident has the right to be free from abuse. The community must adhere to policies and procedures that include the following components: reporting. Allegations shall be reported immediately to: The Executive Director/Administrator. State Survey and Certification agency through established procedures. The community will utilize of the following recommendations for prevention of abuse of residents: React to all allegations of abuse by residents. The community will consider factors indicating possible abuse including, but not limited to, the following possible indicators: Resident report of abuse.</p>		

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Respond appropriately to all alleged violations.</p> <p>(continued on next page)</p>		

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R1 was then brought to common area and said, The lady abused me. I'm gonna call V7 (Family Member). The facility did not have an abuse investigation report for R1's abuse allegation from 05/21/2025. On 08/13/2025 1:53 PM V2 (Director of Nursing) stated R1 had a history of making allegations prior to admission towards caregivers and families, doesn't know if the documentation regarding R1 stating the lady abused me, would be considered an allegation, doesn't know what the writer meant. R1 has impaired cognition this would not change that an allegation was made but may affect V2's perception of what happened. The allegation would still have to be investigated if V2 were made aware of it, this should have been reported to the administrator. If the nurse would have informed V1 or V2 that R1 stated someone abused her V2 would have notified the administrator. If something is reported or seen in the community, we immediately report it to our administrator. The proper protocol would have been followed if she or V1 would have been notified about the allegations of abuse from R1. On 08/14/2025 from 10:26 AM - 11:30 AM V1 (Administrator) stated they spoke to the nurse and aide involved with caring for R1 on 05/21 and the nurse made the clinical decision to document the comment about being abused and wanting to call V7 (Family Member) from R1 to demonstrate her psychiatric behavior in conjunction with other behaviors displayed during that time, and quoted this because the nurse was just attempting to document paranoid and delusional behavior. What we have done for R1 is have multiple care plans in place based on three care plan meetings since she arrived to the facility and have been documenting on her behaviors of paranoia and delusions and consulted with psychiatry to coordinate her care. V1 stated V6 (Certified Nursing Assistant) was the staff being accused by R1 of abusing her on 05/21 and was the aide working with R1 during that time. V6 had informed the nurse that R1 went in the bathroom alone and when V6 went in there to monitor her, R1 didn't want her there and became upset when V6 stated she was there because she didn't want her to slip and fall. When V6 brought R1 out to the common area R1 made the abuse accusation and V6 told V4 (Registered Nurse) what happened and knew that R1 was upset with her for intervening in R1's care. V6 reported to the nurse that there was urine on the floor, and she was assisting R1 because she was engaging in behavior that wasn't safe. When asked by the surveyor once the allegation of abuse was made to V4 what should have been done, V1 responded if someone makes an allegation of abuse the accused staff member is put on leave pending investigation for the safety of that resident and other residents. On 08/14/2025 at 11:42 AM V8 (Medical Director) stated the nurses are trained to quote the patient, the nurse that documented R1's allegation of abuse was quoting the patient not expressing an opinion, just because the patient uses the word abuse the nurse still can use clinical judgment to determine if it's a concern or not, this does not necessarily require investigation if the patient repeats things multiple times. V8 stated there is a certain amount of leeway the facility has and if we investigate every single thing a person is saying we'll be investigating everything, the nurse has the ability to use her clinical judgment to determine whether an investigation of what is being said needs to be done, if someone cries abuse because a band aid is ripped off or says someone was trying to poison them it doesn't necessarily require investigation, R1 has a history of complaining about every little thing and claiming someone quote on quote abused her. On 08/14/2025 at 11:47 AM V1 (Administrator) confirmed that no other staff was present with V6 (Certified Nursing Assistant) when she was monitoring R1 on 05/21 after being found in the bathroom by V6 standing in urine. When asked by the surveyor if there were any other witnesses present to confirm R1's allegation of abuse towards V6 (Certified Nursing Assistant) reported to V4 (Registered Nurse), V1 stated she had not yet had an opportunity to speak with anyone about this and she had not yet investigated this information. On 08/14/2025 12:52 PM V1 (Administrator) stated she followed up with V4 (Registered Nurse) and V4 doesn't recall or remember anyone else being in the room with V6 (Certified Nursing Assistant) on 05/21 when she was</p>		