

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 12/07/2025
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)
<p>F 0656</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to implement care plan interventions during ambulation and transfer which affected one resident (R1) that required hospital transfer. This failure resulted in staff's inability to prevent a fall and R1 sustaining a hip fracture. Findings include: R1 is an [AGE] year-old, originally admitted on [DATE] with medical diagnosis that include and are not limited to: Parkinson's Disease, Dementia and Obstructive and Reflux Uropathy, according to Minimum Data Set (MDS), R1 has a Brief Interview for Mental Status (BIMS) score of 3/15, indicating severe cognitive impairment. According to R1's electronic medical record, care plan dated: 9-9-2025 reads: R1 has an Activities of Daily living (ADL) self-care and mobility usual performance deficit related to Parkinson's dementia with agitation, insomnia and behaviors.</p> <p>Interventions: R1 to ambulate with contact guard in the hallway and a gait belt on for safety with a wheeled walker. On 12-6-2025 AT 3:10 pm V3 (Registered Nurse) said I was the nurse on 11-26-2025 at about 9:30 pm. R1 was observed coming out of his bedroom walking without using the walker and going to next room, I immediately intervened and asked V5 (Certified Nurse Assistant) to stay with R1 while I will get the walker. R1 had a shuffling gait, I walked next to R1 to the main common area in front of the nurse station and I gave R1 ice cream and sat R1 in a recliner chair, R1 ambulated with the walker, R1 did not have any gait belt on, I was having a direct supervision from the nurse station. At about 10:00pm, after R1 ate the ice cream, R1 stood up and walked towards the nurse station, I got up and provided the walker but R1 refused to use it by waving his hands to signal no. I was positioned on R1's right side while walking with him toward his room. After we had taken approximately 5-6 steps away from the nurse's station, R1 leaned to his left, lost his balance, and fell. The fall occurred very quickly, and I was unable to prevent it. R1 was not wearing a gait belt at the time, having a gait belt in place would have assisted me in supporting R1. I assessed R1 and with V5, we transferred R1 to a wheelchair and I kept him by the nurse station, I gave a pain medication, R1 was calm and sleepy, no complaints of pain or discomfort. I called the family, and the medical director received orders to transfer R1 to a local hospital for evaluation. According to local hospital report dated 11-27-2025, R1 will be admitted with left hip fracture. On 12-6-2025 at 2:50 pm V5 (Certified Nurse Assistant) said, R1 is very confused, hard to re-direct, on 11-26-2025 when he had a fall, R1 did not have any gait belt on. On 12-6-2025 at 4:45 pm V2 (Director of Nursing) said, I expect for V3 to use the gait belt on R1 since is one of the interventions in the care plan. On 12-6-2025 V1 (Administrator) presented policy titled: Gait Belt, dated: 6-1-2023 reads in part: It is the standard of the community to use a gait belt for all residents in accordance with assessed needs, the care plan and standards of practice in order to provide optimal safety. Gait belts are to be used for all transfers that require staff assistance and when assisting residents to ambulate.</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
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