STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145724	A. Building B. Wing	03/27/2026

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 0689 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. Based on interviews and record reviews, the facility failed to implement safety measures during transfer back to wheelchair from standing position resulting in R1's fall, hospitalization and sustaining a facial laceration, nasal fracture and neck fracture (type 2 odontoid fracture) and R1 passing in the facility.Findings Include:On 3/26/2026 at 12:13 PM V6 (Activity Aide/Assistant) stated she witnessed R1 pushing his wheelchair while walking. V6 demonstrated and said she took the wheelchair from R1, turned the wheelchair around by placing it behind R1 and verbally instructed R1 to sit down. In the process of R1 trying to sit back down, R1 fell forward hitting his head and face to the floor. V6 said she positioned herself behind the wheelchair. V6 said there was no gait belt used. V6 screamed and asked for assistance after learning R1 had injuries from the fall. During demonstration, V1(Administrator) was present.On 3/26/2026 at 9:52 AM V1 (Administrator) and V2 (Director of Nursing) stated R1 returned to facility and family opted for hospice care for remainder of his stay.On 3/27/2026 at 11:20AM V12 (Physical Therapy) demonstrated and stated to safely transfer a resident from a standing position to sit back down on the wheelchair, staff should stand in front of the resident not behind, apply gait belt, and assist back to wheelchair. This is important to prevent frontal falling. R1 is not safe to walk by himself, staff should be present during ambulation. During demonstration, V2 (Director of Nursing) was present. V2 stated activity aides are not trained to transfer and should call for assistance. R1 admitted to facility on 7/1/2025. Medical diagnosis included (not a complete list) acute hematogenous osteomyelitis, left ankle and foot, Alzheimer's disease, unspecified dementia, unspecified severity, with agitation, need for assistance with personal care, unspecified osteoarthritis, unspecified site. Care plan report, date initiated, 7/1/2025, read Focus: The resident has an ADL self-care and mobility usual performance deficit r/t dementia with behaviors, OA, cardiomyopathy, heart failure, Afib and s/p left foot toe osteomyelitis and amputation 2/27 readmitted type 2 odontoid fracture, nasal fx s/p fall. Interventions: Chair/bed to chair transfer: mod changed to Max x2. admission Evaluation/ Fall Evaluation, 12/21/2025 read Intervention: Anticipate and meet the resident's needs. MDS - Assessment Information, Target date 2025-12-26 Section GG read E. Chair/bed-to-chair transfer: The ability to transfer to and from a bed to a chair (or wheelchair), substantial/max assistance. Physical Therapy Treatment Encounter Note, date of service 2/26/2026 read R1 ambulated 50' X2 on level surfaces with min assist and w/c (wheelchair) follow with FWW.Policy and Procedure, reviewed date 12/1/2025Subject: Fall Prevention & Management PolicyPolicy:Franciscan Ministries has a Fall Management Program in place to ensure that the community's residents are assessed utilizing a standardized tool for their potential fall risk and to guide in implementing person-centered interventions to decrease the frequency or severity in the event a fall does occur.Fall prevention is achieved through an interdisciplinary approach of education, managing risk factors, and implementing appropriate interventions to reduce the risk of falls.Actions following a fall include:2. Determining what may have caused or contributed to the fall.3. Addressing the factors for the fall.

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