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	05/28/2026

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	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to effectively address R2's behaviors, put effective fall interventions in place, and provide appropriate hands-on ADL care to one resident (R2) who is high risk for falls. This failure resulted in R2 falling out of bed while being provided with care and sustaining multiple lacerations to his face requiring six sutures in total.Findings Include:R2 is a [AGE] year-old male who originally admitted to the facility on [DATE] and continues to reside in the facility. R2 has multiple diagnoses including but not limited to the following: Alzheimer's disease, dysphagia, cognitive communication deficit, muscle weakness, and repeated falls.Facility Reported Incident dated 4/19/2026 states in part but not limited to the following: On 4/19/2026 at 5:20AM, V5 (Certified Nursing Assistant) provided care to R2. V5 was obtaining supplies from the wheelchair that was positioned at the foot of the bed when R2 was observed to be in a sitting position, feet on the ground and was holding onto the grab bar. It was determined that R2 attempted to get out of bed and made contact with the bedside table, resulting in active bleeding and injury to the facial area. Staff reported that R2 has a history of attempting to self-transfer and may exhibit intermittent agitation during care.Hospital record dated 4/19/2026 shows R2 sustained 4 total lacerations to the face which required 6 sutures due to the incident including: two sutures near the right eye, two sutures on the right nose, 1 suture on the right chin, and 1 suture inside the right chin.On 5/26/2026 at 11:57AM, V5 said I was providing incontinent care to R2 in bed. I turned around to grab an incontinent brief from his wheelchair and during this time, R2 rolled over and was hanging on the bed. He must have hit his head on the nightstand because he was bleeding from his face.V5 said R2 has a history behaviors such as trying to stand up without asking for assistance. R2 needs increased supervision and we try and keep him in communal areas to provide supervision.At 11:35AM, V4 (Certified Nursing Assistant) said I work with R2 often and am very familiar with him. R2 is very confused and can become impatient with staff in the middle of care. He will try and move around or stand up while you are providing ADL care to him. He needs increased supervision due to these behaviors of consistently trying to stand up and not asking for assistance.It is to be noted that V2, V3, V6, and V8 all expressed the knowledge of R2 having behaviors such as standing up without assistance or getting impatient with staff during care.On 5/27/2026 at 12:15PM, V2 (Director of Nursing) said after investigating the fall, I did provide one on one education to V5 to ensure that when he is changing R2 he keeps incontinent supplies within reach and puts his hand on the resident while grabbing supplies. We also now provide two person assistance to R2 when providing incontinent care due to his unpredictable behaviors.Inservice education sheet dated 4/22/2026 states in part but not limited to the following: Ensure all necessary supplies and equipment are gathered and within reach prior to initiating resident care to prevent leaving the resident unattended and to promote safety and efficiency. This in-service is noted to be provided by V2 to V5.Care plan for R2 states in part but not limited to the following: R2 is at risk for falls related to Alzheimer's Disease, unaware of safety needs, sleep pattern disturbance, insomnia, and restless at night. R2 has history of falls prior to admission. Interventions include but not limited to the following: anticipate and meet R2's needs, ensure R2 is positioned near staff for closer monitoring (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0689 Level of Harm - Actual harm Residents Affected - Few	and provide redirection; and ensure R2 is properly positioned in the middle of the mattress when in bed.Facility policy titled Fall Prevention and Management Policy with most recent review date of 12/1/2025 states in part but not limited to the following: Fall prevention is achieved through an interdisciplinary approach of education, managing risk factors, and implementing appropriate interventions to reduce the risk of falls. The community will provide adequate supervision to prevent accidents.