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	01/16/2025

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 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Notify the resident or the resident’s representative in writing how long the nursing home will hold the resident’s bed in cases of transfer to a hospital or therapeutic leave. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50036 Based on interview and record reviews, the facility failed to provide bed hold notifications to residents and/or family members when residents were discharged to a local hospital. This failure affected 5 residents (R5, R19, R37, R64 and R120) reviewed for bed hold notification in a total sample of 38. This failure had the potential to affect all residents in the facility. Findings include: R5 originally admitted on [DATE] with diagnosis that include and are not limited to: pneumonia, sepsis, dysphagia and acute kidney failure. Resident was transferred to a local hospital on 1/6/2025 per progress notes. Per record review no bed hold notification on record. R19 originally admitted on [DATE] with most recent readmission on 1/4/2025 with diagnosis that include and are not limited to: pick's disease, hemiplegia and hemiparesis following cerebral infarction affecting right dominant side, dysphagia and aphasia. Resident was transferred to a local hospital on 11/9/2024 and 12/30/2024 per progress notes. Per record review no bed hold notification on record. R37 originally admitted on [DATE] with most recent readmission on 12/21/2024 with diagnosis that include and are not limited to: calculus of bile duct with acute cholecystitis with obstruction, muscle weakness, difficulty in walking and cognitive communication deficit. Resident was transferred to a local hospital on 10/24/2024, 12/16/2024 and 12/19/2024 per progress notes. Per record review no bed hold notification on record. R64 originally admitted on [DATE] with most recent readmitted d 11/5/2024 with diagnosis that include and are not limited to: Alzheimer's disease, cognitive communication deficit, anemia and generalized anxiety disorder. Resident was transferred to a local hospital on 10/31/2024 per progress notes. Per record review no bed hold notification on record. R120 originally admitted on [DATE] with most recent readmission on 1/5/2025 with diagnosis that include and are not limited to: displaced fracture of base of neck of left femur, hemiplegia and hemiparesis, muscle weakness and dysphagia. Resident was transferred to a local hospital on 12/29/2024 per progress notes. Per record review no bed hold notification on record. (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: 145724	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/16/2025
NAME OF PROVIDER OR SUPPLIER: Addolorata Villa		STREET ADDRESS, CITY, STATE, ZIP CODE: 555 McHenry Road Wheeling, IL 60090	

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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 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 01/15/25, at 2:41 PM, V1 (Administrator) was asked to provide surveyor the bed holds for the listed 18 discharges from hospital in the last three months. V1 stated, it has not been documented in the records. We are in the process of in-servicing the nursing staff on the proper procedure. On 1/15/2025, at 2:52 PM V2 DON (Director of Nursing) stated, regarding bed hold policy my expectation for the staff moving forward is communication with families and residents. I am not familiar with the bed hold policy. I remember from years ago I remember sending something with the patient when they discharged . The nurses are not aware of bed hold policy. We communicate with the families when they are discharged . We let them know what we are sending them out for, that we got the order. We call for follow up with the hospital. The hospital will usually ask us if they will come back to facility. We leave their belongings the same in their room unless family states that resident expires or are transferring elsewhere. Going forward I have started reviewing something that was given to me and started an in-service with the nurses on our bed hold policy. I am working on the verbiage so families and staff can understand it. Bed hold policy has not been being followed in the whole facility. On 1/15/2025, at 3:11 PM V1 stated, regarding the bed hold policy, it has not been being done in the whole facility. We are in the process of educating staff now. I do not know how this could have gotten overlooked. We do not charge any residents for any bed holds. For Medicare residents, we do not charge a bed hold. Private pay we do charge for the room whether they are here or not if belongings are in room. We do not kick residents out after the 10 days. The resident belongings stay in the room when they are discharged out to hospital. We do not move their belongings. Bed Hold Notices Policy with effective date of 5/1/2019 documents (in part): Policy: Franciscan Ministries supports the resident and/or resident's representative's right to be informed of the policy regarding holding a bed prior to and/or upon a resident's transfer to the hospital, therapeutic leave or discharge, including the duration of the bed hold. Purpose: To ensure a resident has the information regarding his/her rights regarding bed holds. Procedure: Notice Before Transfer 1. The following information is given to the resident and/or resident representative. a. The duration of the State bed-hold, if any during which the resident is permitted to return and resume residence in the nursing community. b. The reserve bed payment policy in the State plan, if any; and c. The community policy regarding bed hold periods to include permitting residents to return. 2. Policy Administration: 3. 2. The Executive Director/Administrator and Director of Nursing share responsibility for the implementation and communication of this policy. (continued on next page)

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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	4. 3. The Executive Director and [NAME] President of Clinical Services share responsibility for monitoring and reporting on implementation of this policy. This responsibility includes bringing to the attention of the Senior Management or the Board instances where this policy is not being applied.

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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 0686 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34071 Based on observation, interviews and record reviews, the facility failed to assess and prevent the development of a pressure ulcer for one ((R28) of two residents reviewed for pressure ulcers. This deficiency resulted in R28's intact skin developing a facility acquired Unstageable pressure ulcer. Findings include: R28 is a [AGE] year-old, female, admitted in the facility on 11/22/24 with diagnoses of Heart Failure, Unspecified; and Nondisplaced Fracture of Medial Malleolus of Right Tibia, Subsequent Encounter for Closed Fracture with Routine Healing; Other Fracture of Upper and Lower End of Right Fibula, Subsequent Encounter for Closed Fracture with Routine Healing. MDS (Minimum Data Set) dated 11/28/24 documented R28's BIMS (Brief Interview for Mental Status) score of 11 which means moderate impairment in cognition. MDS also recorded R28 has no pressure ulcer. R28's 11/29/24 Braden score for predicting pressure sore risk was 13, which means moderate risk. R28's progress notes recorded the following in part but not limited to the following: 11/22/24 - came from hospital, admitted due to ankle injury. 11/23/24 - skin/wound note: skin is generally intact 12/04/24 - skin/wound note: noted pressure injury on sacrum 1 x 1.5 cm (centimeters); informed V27 (Nurse Practitioner) V16 (Wound Care Nurse). Cleansed with NSS (normal saline solution), applied silver alginate and foam dressing. Monitored accordingly. All needs attended. Endorsed. 12/07/24 - skin/wound note: received report of pressure injury of sacrum. V17 (Wound Doctor) notified, and treatment obtained, adjusted and carried out. 12/09/24 - changed to air mattress for pressure wound. 12/16/24 - continued to have US (Unstageable) PI (pressure injury) to sacrum (1 x 1.2 x 0.1). R28's POS (Physician Order Sheet) recorded the following: 12/07/24 - low air loss mattress pressure redistribution mattress for PI treatment 12/07/24 - sacrum: cleanse with NSS. Apply santyl ointment and calcium alginate and foam dressing every evening shift every other day and as needed for pressure injury. 12/08/24 - sacrum: cleanse with NSS. Apply santyl ointment and calcium alginate and foam dressing as needed for pressure injury 12/09/24 - sacrum: cleanse with NSS. Apply santyl ointment and calcium alginate and foam dressing every evening shift every other day and as needed for pressure injury. (continued on next page)

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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 0686 Level of Harm - Actual harm Residents Affected - Few	12/23/24 - sacrum: cleanse with NSS. Apply skin-prep to periwound. Apply silver alginate and foam dressing as needed for pressure injury. 12/23/24 - sacrum: cleanse with NSS. Apply skin-prep to periwound. Apply silver alginate and foam dressing every evening shift every other day for pressure injury. R28's wound notes recorded the following: 12/09/24 - Unstageable (due to necrosis) sacrum- 1 cm x 1.2 cm x not measurable cm 12/17/24 - Stage 3 pressure wound sacrum - 0.8 cm x 0.9 cm x 0.1 cm 12/31/24 - Stage 3 pressure wound sacrum - 0.8 cm x 0.7 cm x 0.1 cm 01/14/25: Stage 3 pressure wound sacrum: 0.3 cm x 0.3 cm x 0.1 cm; alginate calcium with silver apply once daily for 8 days; foam silicone border apply once daily for 23 days; skin prep apply once daily for 23 days. On 01/13/25 at 10:38 AM, R28 was in bed, alert, oriented. Observed a wrapped bandage on right lower leg. R28 stated, she had a recent fall and broke her ankle. R28 also verbalized she was not sure about her pressure ulcers. R28 is currently on physical therapy. On 01/14/25 at 12:56 PM, wound care observed on R28, provided by V22 (Registered Nurse, RN) assisted by V21 (Certified Nurse Assistant, CNA). R28 currently has a Stage 3 pressure ulcer on the sacral area. R28 stated, I haven't heard of my wound until a couple of weeks ago. The sacral wound is small, dry, no discharges. The skin around wound is intact. On 01/15/25 at 12:02 PM, V19 (RN) was asked regarding R28's pressure ulcer on the sacrum. V19 replied, V18 (CNA) told me about it when she was cleaning her (R28). It was a pressure injury already. There was no endorsement from the previous shift that she had any skin alteration or wound. I was shocked when I saw it. The wound was like the size of a pea. It was open, red. I called nurse practitioner and ordered silver alginate. I did the dressing and I also inform V16 and V17. That time she stays in bed most of the time due to injury in her right ankle. On 01/15/25 at 2:35 PM, V18 was also interviewed regarding R28. V18 stated, I worked afternoon shift. During incontinence care, I noticed redness on the lower back. That was the first time I saw the redness. And I reported it V19. R28's Skin Assessment for Care Partner Use (Shower sheets) documented the following: 12/31/24 - no skin alteration. Per progress notes dated 12/04/24, pressure injury was noted on sacrum. There were no other shower sheets provided by facility for R28. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	On 01/15/25 at 5:52 PM, V16 was asked about what happened to R28's wound on the sacrum. V16 verbalized, I was notified that they noted skin damage on her (R28) skin. When I saw it the next time I was in the facility, it was pressure ulcer, it was Unstageable. She was admitted with intact skin. I notified V17, and he ordered santyl with calcium alginate. Every time I see her (R28) I asked her did you get up; did you sit in the wheelchair. She says she likes to be lying in bed. I was encouraging her to offload. V16 was also asked on her expectations on staff to prevent pressure ulcer development. V16 stated, We have to encourage her to get up and get out of bed; turning every two hours at least; changing the brief as needed as frequently as possible. She (R28) is alert and oriented. Staff when they change the brief, they make sure she is dry, check for any skin abnormalities. I don't have any information regarding her wound because the nurse told me the skin issue when she called me. The skin was already damage. Floor nurses should do treatment as ordered. As soon as I saw her skin damage, I placed her on low air loss mattress. Low air loss mattress is indicated for Stage 3 and higher. Further review of progress noted dated 12/04/24 recorded R28 was noted to have pressure injury on the sacrum. Progress notes dated 12/09/24 documented her (R28) regular mattress was changed to air mattress for pressure wound. POS dated 12/07/24, low air loss mattress pressure redistribution mattress had been ordered for R28's pressure injury treatment. Wound notes dated 12/09/24 recorded an Unstageable sacrum pressure ulcer on R28. R28's care plan dated 12/07/24 documented: Has Stage 3 pressure injury on sacrum related to limited mobility, fragile skin: Interventions - resident (R28) requires air mattress to bed and cushion to wheelchair. On 01/15/25 at 5:37 PM V17 was interviewed regarding R28's pressure ulcer on the sacrum area. V17 mentioned, I have been treating R28's wound since December 2024. I see the wound every week. It was Unstageable pressure ulcer when I first saw it. We have been treating it with santyl. It was measured 1 cm x 1.2 cm at first. Right now, she's on silver alginate. The wound is pretty small now, it measures 0.3 x 0.3. When I first saw it was Unstageable pressure ulcer, not sure the depth of sacrum injury. There was 30% slough on it that is why I could not stage it. She was admitted for rehab, she needs to be gotten out of bed and try to get her mobile. Everyone is at risk to develop pressure ulcer. It is hard to say when the wound developed. Wound treatments should be implemented as ordered. On 01/16/25 at 11:46 AM, V2 (Director of Nursing) was asked regarding expectations on staff in prevention and management of pressure ulcers. V2 stated, Staff perform pericare as needed and frequent monitoring and attending to residents' needs; repositioning; toileting residents in a timely manner. CNAs assess skin during care and notify nurses for skin issues. Nurses assess skin and notify wound doctor and wound nurse for any issues and if there are orders, orders are carried out and implemented until resident is seen. Facility's policy titled, Management and Treatment of Pressure Ulcers, dated 06/01/2023 stated in part but not limited to the following: Policy: The community will have protocols in place in the event a newly identified pressure ulcer is noted. The direct care staff will initiate an appropriate treatment to the wound until the time it is further assessed by the Wound Care Nurse. Any newly identified pressure ulcer will have treatment initiated at the time of discovery. The policy for skin presented by facility did not specifically address assessment and prevention of pressure ulcers.

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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	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** 34071 Based on observation, interviews and record reviews, the facility failed to adequately monitor and supervise a cognitively impaired resident in preventing a fall for one (R120) of five residents reviewed for accidents and supervision. This deficiency resulted in R120 falling from a wheelchair in the common area in the facility and sustaining an acute subcapital femoral neck fracture. R120 underwent a surgical procedure called left hip hemiarthroplasty. Findings include: R120 is a [AGE] year-old female, initially admitted in the facility on 12/11/24 with diagnoses of Dementia in other Diseases Classified Elsewhere, Unspecified Severity with other Behavioral Disturbance; Unspecified Lack of Coordination; and Repeated falls. R120 was readmitted on [DATE] with diagnosis of Displaced Fracture of Base of Neck of Left Femur, Subsequent Encounter for Closed Fracture with Routine Healing. MDS (Minimum Data Set) dated 01/09/25 documented a BIMS (Brief Interview for Mental Status) score of 3, which means severe impairment in cognition. Fall risk evaluation dated 12/11/24 indicated a fall risk score of 85, which means R120 is a high fall risk. Incident report dated 12/28/24 documented: R120 had a fall from wheelchair. Nurse at nurses' station saw R120 kneeling and assisted her (R120) to the floor. R120 was in her wheelchair and the next time nurse looked up, R120 was kneeling on the floor in front of her wheelchair. R120 was on her left knee with right leg outstretched in front of her and her bottom resting on her left foot. Nurse responded immediately and assisted her to the floor. X-ray was ordered. R120 was sent to the hospital for further evaluation and treatment. R120's Xray report dated 12/28/24 recorded: Conclusion - Acute subcapital femoral neck fracture. Hospital record dated 12/28/24 documented a surgery called left hip hemiarthroplasty was performed on R120 on 12/30/24. R120's progress notes documented the following in part but not limited to the following: 12/18/24 - has exhibited sun downing behavior and will become agitated in the afternoon which occurred last evening on 12/17/24. She yells at the staff and wants to know when she is leaving. Per nurse on duty, she also made attempts to get up without regard to her own safety and needs close monitoring due to poor safety and awareness. 12/18/24 - resident alert and oriented x 1-2, forgetful and confused. Attempts to get up very often without call for help. Resident (R120) needs monitoring all the time. Afternoon became more sundowning. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	12/18/24 - Around 4 PM, R120 started to become agitated with several attempts to stand up from her chair. When asked if she needed anything, she stated that she wanted to be away from the rest of the people in the common room and wanted to sit near the window. Done as requested. After several minutes, R120 again starts to stand up. When asked what she wanted, she asked the nurse why she was placed there away from other people. Explained that she requested to sit near the window. 12/22/24 - R120 noted standing up in common area room through shift. NOD (Nurse on Duty) educated R120 on safety. Education noted ineffective, resident non-compliant to education provided by NOD. 12/24/24 - R120 with poor safety awareness continuously attempting to get up from wheelchair without asking for assistance. Resident at times difficult to redirect, provided 1:1 self-directed activity with negative effect. Resident is with another associate for close monitoring. 12/28/24 - At 12:50 PM, this writer (V24, Registered Nurse, RN) was next to the nursing station with the medical cart, when I observed that R120 was trying to walk on the common area, lost her balance and was going on the floor between the big white table and her wheelchair. This writer was able to catch her and lower her on the floor. Her left knee was banded, and LLE (left lower extremity) was toward her right side (she was kneeling on her left side and set down on her left leg). No visible injury noted during head to toe assessment. R120 complained of pain to LLE. STAT (immediate) Xray to LLE and left hip was ordered. 12/29/24: notified the result and advise writer to send out R120 to hospital via regular ambulance. 01/05/25 - readmitted from hospital. On 01/13/25 at 11:00 AM, R120 was observed sitting in her wheelchair in the common area. She is alert, verbal, oriented. She was asked regarding recent fall, stated she does not know what happened. On 01/14/24 at 11:20 AM, V24 was interviewed regarding R120's recent fall incident. V24 stated, On 12/28/24, I was assigned to the first floor. I witnessed the fall. It was weekend, Sunday or Saturday, before new year. I was standing next to the medication cart in the [NAME] Hallway. She (R120) was in the common area, in her wheelchair. There was a space between her and the table. I was by myself. CNAs were putting residents back to their rooms. I remember the phone rang and I answered the phone. After I answered the phone, I noticed her chair was empty and she was sitting on the floor. Her left leg was under her right leg with right leg extended. I called for help, but nobody was there. I put her on the floor. I did head to toe assessment. There were no bruises, no skin tear, no external rotation on lower extremities. No complaint of pain. She did not hit her head. Then she started to move, she has dementia. When we put her in the reclining chair, we noticed that when she moved, she made facial grimaces. We started to ask her if she had pain, she said yes. We asked if its right leg or left leg. She was asked to show us which leg, she pointed left leg. V25 (Physician) was notified and ordered STAT Xray. V24 was asked regarding supervision and monitoring of residents in the common area. V24 mentioned, In the morning, all CNAs put all residents in the common area. When they are eating, CNAs are there. After eating, they have activities. CNA is supposed to stay with the residents in the common area. Activity staff, CNAs, they take turns in staying with residents. R120 always stand up when in the wheelchair. We redirect her, make her busy and she likes to do activities. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	On 01/14/25 at 10:35 AM, V21 (CNA) was observed in the common area doing computer charting. V21 situated herself closed to the residents. V21 verbalized, Right now, I am watching the residents and charting. Residents are placed here in the common area to watch TV; attend activities like range of motion; playing games. They play cards here, play balloons. This is their common area where they can be together. Usually, we have one person doing the monitoring and stay here with the residents. We make sure someone is watching them closely. On 01/14/25 at 11:00 AM, V23 (Certified Nurse Assistant, CNA) was asked regarding R120. V23 replied, She has dementia, alert and confused. She repeats the same thing you tell her. She doesn't follow directions. She keeps standing up when she's in the wheelchair. We try to have somebody around her and provide activities. If there are no activities, CNAs, nurses do the supervision and monitoring. Most of the time, somebody is in the common area. When we do charting in the computer, we sit with these residents. She (R120) is placed in the common area. If she is in the common area, somebody has to be close to her. If she keeps on standing up, nurse or any staff should run to her and redirect her. We need to sit with her. On 01/14/25 at 11:40 AM, R120 was in the common area, in her wheelchair. She was observed standing up several times. V23 was the staff present in the common area monitoring residents while charting on the computer. V23 approached R120 and asked what she needs. R120 stated she is okay. Subsequently, V23 sat beside R120 for close monitoring and supervision. V22 (Registered Nurse, RN) also stated during interview, R120 is alert, oriented, forgetful, unable to ambulate. She uses wheelchair and always try to get up while in the wheelchair. We redirect her and ask what she needs. We always keep her in the common area. When I am over there, its fine. I supervise them. When I take a break or busy, I call somebody, and they come to help to monitor the residents. R120's care plan documented the following: 1.Behavior: poor safety awareness date initiated 12/18/24: Interventions: Educate family of risks associated with behavior such as falling and/ or obtaining an injury. Encourage to attend programs - likes religious TV, music, reading. Provide frequent cues and reminders to wait for staff assistance. 2.At risk for falls related to left sided weakness status post CVA (Cerebrovascular Accident), dementia date initiated 12/11/24: Interventions: Anticipate and meet the resident's needs. Be sure the resident's call light within reach and encourage the resident (R120) to use it for assistance as needed. The resident (R120) needs prompt response to all requests for assistance. (continued on next page)

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F 0689

Level of Harm - Actual harm

Residents Affected - Few

PT (Physical Therapy) evaluate and treat as ordered or PRN (when necessary).

The resident (R120) needs a safe environment with: (even floors free from spills and/ or clutter, adequate, glare-free light; a working and reachable call light, the bed in low position at night; side rails as ordered, handrails on walls, personal items within reach) high risk for falls also related to CVA with hemorrhagic conversion.

3.Has left hemiplegia/hemiparesis related to stroke date initiated 12/13/24:

Intervention:

Reposition/ambulate as tolerated and at least every 2 hours.

There were no other interventions formulated for R120 addressing behavior of standing up while in the wheelchair in the common area.

On 01/14/25 at 1:44 PM, V25 (Physician) was asked regarding R120 and fall. V25 verbalized, I have been taking care of R120 since admission. She stays in the wheelchair. She is impulsive, she moves around on her own, she should be kept in the nurses' station. She has significant cognitive impairment; alert oriented x 1-2 (alert, oriented to self and place). I was notified regarding her recent fall. I expect staff to do frequent rounding in the TV (television) room/common area on a constant basis keeping an eye on the residents. It could be CNAs, nurses monitoring and supervising her. Facility has to follow their fall protocol.

On 01/15/25 at 9:55 AM, V2 (Director of Nursing) was also asked regarding supervision and monitoring of residents in the common area. V2 stated, When there are residents out in the common area, it is supervised either by CNA, nurses or unit secretary and if they have to leave the unit or area, they will notify our scheduler or life enrichment staff who will go out there to supervise. Anybody can sit in the common area and monitor the residents. R120 is alert and has impaired cognition. She is here for short term rehab. Prior to facility admission, she had stroke. She is on extensive assist, incontinent of bowel and bladder. She is high risk for falls. Prior to her recent fall, we make sure we anticipate her needs, and she is to be placed in the common area when she is awake. We do frequent rounding on her and everybody in the common area, we have staff monitoring the common area. She (R120) had a fall incident on 12/28/24 at 12:50 PM. She was attempting to get up from the wheelchair. She was restless, attempting to get up. Her cognition is impaired and unable to let staff know what she needs. She wants to stand up from the wheelchair and she is redirected whenever staff observe it. The staff has to approach her (R120) and ask her what she needs, sit with her and make sure she is safe. The incident happened after lunch, the staff were assisting other residents to go back to their rooms or providing care. The nurse was the only one monitoring the resident and she was by the med cart.

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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 01/16/2025

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	Facility's policy titled Fall Prevention & Management Policy, dated 10/23/24 documented in part but not limited to the following:Policy: (Name of organization) 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. CMS's (Centers for Medicare and Medicaid Services) definition of a Fall refers to unintentionally coming to rest on the ground, floor, or other lower level, but not as a result of an overwhelming external force (e.g. resident pushes another resident). An episode where a resident lost his/her balance and wound have fallen, if not for staff intervention, is considered a fall. All without injury is still a fall. Unless there is evidence suggesting otherwise, when a resident is found on the floor, a fall is considered to have occurred. Fall prevention is achieved through an interdisciplinary approach of education, managing risk factors, and implementing appropriate interventions to reduce the risk of falls. There is no one medical professional responsible for identifying and managing fall risk. Medical professionals, family members, as well as support staff in the community (housekeeping, maintenance, dietary, etc.) are equally important and can provide insight to managing fall risk. Supervision - The Community will provide adequate supervision to prevent accidents. Adequacy of supervision is defined by type and frequency based on the individual resident's assessed needs and identified hazards in the resident environment. Adequate supervision may vary from resident to resident and from time to time for the same resident.

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 01/16/2025
NAME OF PROVIDER OR SUPPLIER: Addolorata Villa		STREET ADDRESS, CITY, STATE, ZIP CODE: 555 McHenry Road Wheeling, IL 60090	

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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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50519 Based on observation, interview and record review, the facility failed to perform proper hand hygiene, failed to follow proper food storage practices, and failed to ensure dishwasher maintained proper temperature during final rinsing cycles to prevent the spread of food-borne illness and contamination. These failures have the potential to affect all 87 residents receiving meals from the kitchen. Findings include: On 01/13/25 at 09:25AM during the initial kitchen tour with V4 (Director of Dinning Services), surveyor observed three 50 pound bags of carrots on the floor, half full containers of: flour, salt, sugar, and navy beans without open and used by dates. V4 said, the carrots should not be placed directly on the floor and the flour, salt, sugar, and navy beans must be labeled with the open date and used by date. V4 said, he did not know what happened and that the staff are expected to follow the facility policy to label and date food when it is opened. On 01/14/25 at 09:25AM surveyor checked the temperature for the dishwasher with V4. Surveyor observed final rinse temperature of174 Fahrenheit (F) and repeat of final rinse at 175F. Surveyor requested for the high temperature dishwasher policy and specifications. V4 said, the dishwasher machine the facility uses, the final rinse is expected to be between 180F to 190F and V4 will be calling a local company to come and check the dishwasher machine. On 01/14/25 at 11:36 AM surveyor observed resident dining in [NAME] dining room on first floor. V12(Dietary Server) observed opening refrigerator with gloves on, removed saran wrap from plate of tomato and lettuce, touched the tomato and lettuce and added it to lunch plate for R40 with the same gloved hands. Surveyor did not observe V12 perform hand hygiene. Surveyor asked V12 if she should have washed her hands and changed gloves after touching refrigerator and prior to touching residents' food. V12 said, I think so. On 01/15/2025 at 11:50AM V8 (Local company Account Representative) said, when the dish washer machine final rise temperature was checked on 01/14/2025 at 12:09PM, the temperature of the final rinse was not holding up, and the dishwasher temperature was switched to low temperature with chemical rinse, because there were no parts available to fix the machine at that time and ordered the parts. V8 said that the machine requires 6 elements, and one element was not working. V8 showed pictures of exposed wires to the surveyor. and said, that is why the temperature is not holding up. On 01/15/2025 at 9:50AM V2 (Director of Nursing) said, the staff are expected to wash their hands or use hand sanitizer before and after care, after removing gloves and after touching a soiled or dirty surface. Staff in the dining room are required to wash their hands before putting gloves on and before serving meals, and when hands get soiled and when changing tasks. (continued on next page)

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 01/16/2025
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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 01/15/2025 at 9:55AM V3 (Infection Preventionist) said, staff are expected to wash hands or use hands sanitizers all the time, between patients, before and after using personal protective equipment, before and after serving food, before and after passing medications, and when hands get soiled. V3 said, vegetables or food should not be placed directly on the floor because it can cause cross contamination and cause infection. On 01/15/2025 at 11:04 AM V1 (Administrator) said, she was not aware of any concern with the dishwasher or with the final rinse temperatures and V1 works directly with V4 to fix any equipment that is not working properly. V4 usually makes sure that the kitchen equipment is fixed immediately. V1 said, the staff are expected to follow facility policy and not place food directly on the floor and practice hand washing to prevent infection and residents getting sick. Facility policy titled, Sanitation and Infection Prevention/Control Policy number F006 dated issued:5/95 and revised 1/2025 documents (in part): Policy: To prevent communication of food with infections microorganism, Food and Nutrition Services associate are expected to observe the following Infection Prevention and Control Practices. Procedure: Use a spatula or tongs or wear disposable gloves when handling food, do not touch food with bare hands, do not perform multiple activities while wearing gloves which will be used in food handling. Facility policy titled, Sanitation and infection Prevention/Control: Disposable glove use Policy number F021 dated revised: 1/24 documents (in part): Policies: Disposable, no-latex gloves must be worn at the following times, When handling read-to eat-foods, When handling clean utensils/dishes/equipment, When handling soiled dishware Procedure: Disposable gloves must be changed and handwashed when gloves are dirty or ripped and when moving from one task to another, such as moving from handling dirty dishes to handling clean dishes. Facility policy titled, Sanitation and Infection Prevention/Control Policy number F019 date reviewed (1/24) documents (in part): Policies: Dishmachine wash, and rinse water should be maintained at temperatures that meet the guidelines established by the food and drug administration. Single-tank conveyor, dual temperature machine: Wash temperature 160F. Final rinse temperature 180F-194F. Facility policy titled, Production, Purchasing, Storage; Food and Supply storage policy number B003 revised dated (1/25) documents (in part): Policies: All food, non-food items and supplies used in food preparation [NAME] be stored in such a manner as to prevent contamination to maintain the safety and wholesomeness of the food for human consumption. Procedures: Most but all but not all products contain an expiration date, the words sell by, best by, enjoyed by or used by should precede the date. Food past the used by date, sell by, best by, or enjoyed by date should be discarded. Cover, label, and date unused portion opened packages. Use the medadvantage/fresh date labeling system or complete all section on the [NAME] orange label. Refrigerator Storage: Store items 6 inches above the floor. The bottom shelf must be solid to prevent product from splash and dust. 50036