

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6000046	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 02/08/2024
--	--	---	---

NAME OF PROVIDER OR SUPPLIER ADDOLORATA VILLA	STREET ADDRESS, CITY, STATE, ZIP CODE 555 MCHENRY ROAD WHEELING, IL 60090
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	Initial Comments Facility Reported Incident Investigation 8.23.23/ IL166202 9.28.23/ IL166200 8.30.23/ IL166201	S 000		
S9999	Final Observations Statement of Licensure Violations: 1 of 2 300.610a) 300.1210b) 300.1210c) 300.1210d)6) Section 300.610 Resident Care Policies a) The facility shall have written policies and procedures governing all services provided by the facility. The written policies and procedures shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee, and representatives of nursing and other services in the facility. The policies shall comply with the Act and this Part. The written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, documented by written, signed and dated minutes of the meeting. Section 300.1210 General Requirements for Nursing and Personal Care b) The facility shall provide the necessary care and services to attain or maintain the highest	S9999		

Illinois Department of Public Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE
Electronically Signed

TITLE

(X6) DATE
02/26/24

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6000046	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 02/08/2024
--	--	---	---

NAME OF PROVIDER OR SUPPLIER ADDOLORATA VILLA	STREET ADDRESS, CITY, STATE, ZIP CODE 555 MCHENRY ROAD WHEELING, IL 60090
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S9999	<p>Continued From page 1</p> <p>practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive resident care plan. Adequate and properly supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident.</p> <p>c) Each direct care-giving staff shall review and be knowledgeable about his or her residents' respective resident care plan.</p> <p>d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour, seven-day-a-week basis:</p> <p>6) All necessary precautions shall be taken to assure that the residents' environment remains as free of accident hazards as possible. All nursing personnel shall evaluate residents to see that each resident receives adequate supervision and assistance to prevent accidents.</p> <p>These rquirements are not met as evidenced by:</p> <p>Based on interview and record review, the facility failed to provide appropriate supervision and assistive devices to prevent a mechanical fall for a resident with a history of falls and at high risk for falls; and failed to conduct a safe transfer from wheelchair to standing position for 1 (R4) of 4 residents reviewed for accident/hazards in the sample. This failure resulted in R4 sustaining a hip fracture during a therapy session for which she was to receive continued strength training for gait imbalance; and warranted an emergent transfer to the hospital with required surgical intervention.</p>	S9999		

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6000046	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 02/08/2024
--	--	---	---

NAME OF PROVIDER OR SUPPLIER ADDOLORATA VILLA	STREET ADDRESS, CITY, STATE, ZIP CODE 555 MCHENRY ROAD WHEELING, IL 60090
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S9999	<p>Continued From page 2</p> <p>Findings include:</p> <p>R4 is an alert and oriented 85 year old with diagnosis of pneumonia, muscle weakness, difficulty walking, and spinal stenosis.</p> <p>Fall risk care plan dated 9/24/23 states, "The resident is at high risk for falls related to spinal stenosis, hypertension, neuropathy, dementia, urine and blood infections, and decline in ADLs (Activities of Daily Living). Focus: The resident will be free of falls through the review date. Interventions: Anticipate and meet the resident's needs. Be sure the resident's call light is within reach and encourage the resident to use it for assistance as needed. The resident needs prompt response to all requests for assistance. Educate the resident and caregivers about safety reminders and what to do if a fall occurs. Redirect when making poor safety judgments."</p> <p>On 2/6/24 at 1:00 PM, Surveyor visited the resident in her room to inquire about R4's hospitalization. R4 was seated in a wheelchair in her room with her daughter by her side. R4 was alert and was able to respond to questions appropriately and clearly provided by the surveyor. R4 stated, "I'm in a little pain but I'm fine now. I fell while V4 (PTA-Physical Therapy Assistant) was having me do exercises. She told me to get up from my wheelchair and I don't know what happened, but I just felt weak and all of a sudden, I fell over to my left side and hit the floor really hard, and I was in a lot of pain. I think I might have yelled when I hit the ground, but I can't remember because it went so fast." Surveyor asked where V4 was when she fell, R4 stated, "Well I guess she was right behind me because that's what she told me and that she had to let go of me."</p>	S9999		

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6000046	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 02/08/2024
--	--	---	---

NAME OF PROVIDER OR SUPPLIER ADDOLORATA VILLA	STREET ADDRESS, CITY, STATE, ZIP CODE 555 MCHENRY ROAD WHEELING, IL 60090
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S9999	<p>Continued From page 3</p> <p>V10 (family member) stated " I got a call from V3 (Assistant Director of Nursing) saying that my mom fell during therapy. I was really upset so I called the social worker (V11), and she couldn't explain to me how my mom could fall in therapy where she was supposed to be recovering to get her strength back. Instead, this is a huge setback in her recovery, because now she has to recover from surgery because of her fractured hip. To make matters worse, I spoke to the therapy director (V5), and he told me that my mom's fall was an unexpected accident that he never encountered before. He kind of laughed when explaining this to me because I guess it surprised him that this happened during therapy. I asked him what he found funny and that I didn't find any humor in the situation, as my mom got a fracture due to the actions (or lack thereof) of one of his staff. I also asked about the therapist assistant's (V4) past injury which I found out about from another CNA here. That CNA was questioning why this therapist was even allowed to work with my mom. I asked (V5) and he said he was not aware of V4's past injury as he was the interim therapy director. Needless to say, I wanted to take my mother out of here, but she liked the religious services here." Surveyor asked to reveal who the CNA that claimed V4 was injured, but V10 declined to reveal the identity.</p> <p>On 2/6/24 at 1:20 PM V4 (Physical Therapy Assistant) stated, "When (R4) was finished with OT (Occupational Therapy), the resident had about a 10 minute break and she was placed on her wheelchair by the bathroom door. When we were going to do her therapy, her wheelchair was behind her and I was on her left side. We've done it everyday and when she was last doing therapy. She was already considered a minimal</p>	S9999		

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6000046	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 02/08/2024
--	--	---	---

NAME OF PROVIDER OR SUPPLIER ADDOLORATA VILLA	STREET ADDRESS, CITY, STATE, ZIP CODE 555 MCHENRY ROAD WHEELING, IL 60090
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S9999	Continued From page 4 transfer for her. She was standing and I'm holding her and as she stood up with her first step, she slipped back in the wheelchair in a complete extension away from me. I was holding her using my left arm and she started falling diagonally and forward away from me. It was a split second." Surveyor asked V4 to clarify whether she slipped back or forward as she initially stated that the resident slipped back in the wheelchair, V4 stated, "I meant she fell forward, diagonally but she was going really fast." Surveyor inquired whether she had an existing injury while working on R4, V4 stated, "Yes, back in November I had an injury on my left arm and I had muscle spasms. At that time, I was wearing athletic tape to my left arm." Surveyor asked if she used the same left arm to grab on to R4 to try to catch her fall, V4 stated, "Yes, I always use my left arm and hand." Surveyor asked why she didn't use both arms and hands to stabilize the resident, V4 indicated she was using her right hand to hold on to the wheelchair. Surveyor asked where her focus was during the exercise, the residents' rolling walker, the wheelchair, or the resident, V4 stated, "I had to do all, but this happened so fast." Surveyor asked if R4 fell previously prior to the latest event on 2/1/24, V4 stated, "Yes I think she fell recently and that was why she was here to receive therapy." Surveyor asked if R4 had a recent fall, how the resident's ability would be considered only at "minimal assist", V4 stated, "Well she was able to do exercises before at that level." Surveyor asked if she knew whether R4 was at high risk for falls, V4 stated, "I presumed she was, but she definitely is now." Surveyor asked if a resident is considered at high risk for falls, if she'd allow the resident to walk with only minimal assistance, V4 stated, "Well, we determined she was minimal assist." Surveyor asked the rationale for R4's therapy sessions, V4	S9999		

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6000046	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 02/08/2024
--	--	---	---

NAME OF PROVIDER OR SUPPLIER ADDOLORATA VILLA	STREET ADDRESS, CITY, STATE, ZIP CODE 555 MCHENRY ROAD WHEELING, IL 60090
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S9999	<p>Continued From page 5</p> <p>stated, "For balance training, training with the rolling walker, sit-to-stand, and to regain overall strength."</p> <p>At 1:30 PM, surveyor went with V4 to the therapy gym so she could demonstrate how the fall incident occurred. V4 stated, "The wheelchair was against that wall, the back wheels were locked, and her rolling walker was in front of her (referring to R4). I was to her left side and as she stood up, she just fell forward to her left side. My left hand was holding a gait belt and my right hand was on the wheelchair as we were about to walk with the walker and wheelchair behind her. Then she just fell." Surveyor asked if she had to turn around at anytime and whether she had full control of the resident, V4 stated, "I tried to catch her." Surveyor asked if her attention was drawn away from the resident in order to unlock the rear wheelchair locks to start the exercise, V6 paused and stated, "No I didn't have to unlock them." Surveyor asked how they could start the exercise if the wheelchair was still in locked position as she previously mentioned, V4 had no response. Surveyor asked how she lost control of the resident if she did not have to turn around to unlock the wheelchair, V4 stated, "I had my eyes on her at all times I used my left hand to stabilize the resident and my right hand was on the wheelchair."</p> <p>On 2/7/24 at 11:10 AM, V5 (Therapy director) was asked about R4's fall incident, V5 stated, " We had a conversation with the daughter(V10) later in the afternoon at around 11:30 am on 2/1/24 (V5 checking his phone). The social worker (V11) and myself called and we talked about the incident that occurred during therapy and that her mom was in the hospital and had a hip fracture." Surveyor asked why the therapist involved in the</p>	S9999		

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6000046	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 02/08/2024
--	--	---	---

NAME OF PROVIDER OR SUPPLIER ADDOLORATA VILLA	STREET ADDRESS, CITY, STATE, ZIP CODE 555 MCHENRY ROAD WHEELING, IL 60090
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S9999	<p>Continued From page 6</p> <p>incident didn't call the family member directly, V5 stated, "I can't answer why she didn't make that call." Surveyor asked what he knew happened, V5 stated, "I didn't actually see the incident, but I was informed about it. I was in my office, and I heard a loud noise, a thud, or commotion, so I came out of my office around the corner, and I just saw her (R4) on the ground. I remember going to get the nurse, but the DON was already talking to the resident on the ground." Surveyor asked if he knew if his employee V4 had any prior injuries while working with the resident, V5, stated, "I understand that her left arm felt funny, this is what I was told, but she had no restriction with her left arm to return to work." Surveyor asked if he knew anything about the therapist's injury, V5 stated, "I don't know what happened to her arm. I am only the interim director." V5 continued on and stated, "The patient was seated in the wheelchair and was pushed up against the wall, and a rolling walker was in front of the patient and R4 was wearing a gait belt. V4 (PTA) was holding on to the gait belt with her left hand, and was holding the wheelchair in her right hand. Based on the patient's assessment, her transfer ability was considered a minimum assist. The therapy assistant and patient were going to go for a walk with the rolling walker in front and the wheelchair behind the resident. I was told that she fell all of a sudden during the start of this exercise. Surveyor asked if this incident was preventable had the therapist not relied on R4's perceived ability of only minimal assistance, V5 stated, "I would have to agree with you that the fall was preventable in that sense. She was here to receive strength training, so she probably should have been treated more than the level of minimum to moderate assist."</p> <p>At 12:15 PM, V5 returned and provided surveyor</p>	S9999		

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6000046	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 02/08/2024
--	--	---	---

NAME OF PROVIDER OR SUPPLIER ADDOLORATA VILLA	STREET ADDRESS, CITY, STATE, ZIP CODE 555 MCHENRY ROAD WHEELING, IL 60090
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S9999	<p>Continued From page 7</p> <p>with R4's physical therapy assessments. On this assessment, on 1/29/24, V4 (PTA) wrote that the resident "Required minimum to moderate assist with moderate tactile, visual, verbal cue for safety, proper body mechanics, and to attend to task." Surveyor asked if he agreed with this assessment, V5 stated, "Well, in hindsight I agree with you that the resident needed more than minimal assistance."</p> <p>R4's recent therapy assessment records (12/17/23 to 2/1/24) showed in part, "Treatment Diagnosis: Muscle weakness (generalized). Patient is a 85 year old female who was referred by the primary care physician for subacute rehab status post pneumonia and sepsis with urine ESBL. Patient exhibiting difficulty performing ADL/functional mobility. The functional deficits are caused by weakness, unsteady balance, poor standing with weight bearing tolerance, unsteady balance low endurance. The patient's clinical presentation is stable. Skilled therapy services are medically necessary in order to address deficits, improve quality of life, and assist patient in returning to prior level of function. Therapy Necessity: Therapy necessary for general strengthening and functional mobility re-training. Without therapy, patient at risk for debility and dependence to care. 12/27/23 note entered by V4 (PTA) stated, "Patient instructed on balance strategies and strengthening and range of motion, transfer training with rolling walker. Progression from sitting to standing during ADLs (activities of daily living). Required maximum assist times 1-2 person with maximum tactile, visual, verbal cue for safety, proper body mechanics, and to attend to task. 1/23/2024 note again written by V4 states, "Instructed patient on proper sequencing and hand placement to improve bed mobility and sit to stand and stand pivot transfers moderate</p>	S9999		

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6000046	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 02/08/2024
--	--	---	---

NAME OF PROVIDER OR SUPPLIER ADDOLORATA VILLA	STREET ADDRESS, CITY, STATE, ZIP CODE 555 MCHENRY ROAD WHEELING, IL 60090
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S9999	<p>Continued From page 8</p> <p>/maximum assist. Patient tends to get unsteady on transition."</p> <p>On 2/7/24 at 11:30 AM, V2 (DON- Director of Nursing) was asked about R4, V2 stated, "She is alert times 3 and she is very 'with it'. I was notified of the first fall incident of 1/26/24 and that fall was from a wheelchair too and is the reason why the resident was transferred to us on the skilled side to get therapy for gait training and balance." Surveyor asked the physical condition of the resident after she had fallen on 1/26/24, V2 stated, "I don't really know but the nurse normally taking care of her (V6) said she was more weaker than her baseline, so we felt that it was appropriate for her to get more gait training and strengthening and to get therapy. When we moved her to skilled nursing area, her baseline was a 1- person assist, but physically, she appeared weaker." Surveyor asked what minimum assist means, V2 stated, "It means that the resident can do her ADLs (Activities of Daily Living) such as walking, toileting, etc. on her own and with just minimal assistance and supervision." Surveyor asked if R4 would be considered that if she required physical therapy for gait imbalance, V2 stated, "From a clinical perspective and as the fall the nurse, (R4) appeared weaker with transfers, so the therapist should have been more careful with her, and from that standpoint I guess it could have been avoidable." Surveyor asked if any residents would be considered minimal assistance and with just supervision if they were residents on the skilled side of the facility, V2 stated, "No, that was why R4 was transferred here because she no longer was."</p> <p>On 2/7/24 at 2:10 PM V7 (Restorative Aide) was asked about her statement she provided the</p>	S9999		

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6000046	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 02/08/2024
--	--	---	---

NAME OF PROVIDER OR SUPPLIER ADDOLORATA VILLA	STREET ADDRESS, CITY, STATE, ZIP CODE 555 MCHENRY ROAD WHEELING, IL 60090
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S9999	<p>Continued From page 9</p> <p>administrator pertaining to R4's fall incident. V7 stated, "I normally sit at the desk in the therapy gym, and I saw that (R4) was going over. She went sideways to her left and I saw her falling over. She was on the ground, and she said, "honey my hip hurts". Surveyor asked if she was certain she saw the actual fall or if she just saw her on the ground, V7 stated, "Yes, sorry I did not see the actual action of her falling, she was already on the ground." Surveyor clarified the question again because it was not what was stated on her statement provided to the administrator. V7 stated, "Yes, I'm sure. (R4) was already on the ground. V3 (ADON) helped me write my statement. I'm sorry she put that I saw the resident falling because that's not correct." Surveyor asked if she saw any part of the fall incident, V7 stated, "No I just saw her already on the ground and everyone came and looked at her and then the paramedics came."</p> <p>On 2/7/24 at 2:30 PM V6 (LPN) stated, "I know (R4) very well. She is alert and oriented times 3. She is obese and she cannot walk by herself and she's wheelchair bound. She fell from her wheelchair pretty recently in the shelter area and transferred over to skilled section." Surveyor asked how R4 appeared, V6 stated, "She definitely was a lot weaker than her baseline, so that is why she was transferred to skilled nursing and to get therapy." Surveyor asked if she was aware of the most recent fall incident, V6 stated, "Yes, I heard she fell during therapy, and I was very surprised that it happened in therapy. She fell from her wheelchair last time too, and I was told she fell getting up from her wheelchair again when she was in therapy so that's why I was surprised because she was getting strength training there."</p>	S9999		

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6000046	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 02/08/2024
--	--	---	---

NAME OF PROVIDER OR SUPPLIER ADDOLORATA VILLA	STREET ADDRESS, CITY, STATE, ZIP CODE 555 MCHENRY ROAD WHEELING, IL 60090
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S9999	<p>Continued From page 10</p> <p>On 2/7/24 at 2:45 PM V9 (RN) stated, "I was one of the nurses called in to help by the DON, but she was already assessing the resident. I called the doctor, and he was in the building. The doctor went to therapy to see the resident and I got instructions to call 911 for the resident to be sent out." Surveyor asked if she knew (R4), V9 stated, "Yes, I know (R4), she's usually a two-person assist. I remember that she was weak when she came to us from the shelter care side when she fell over there. She was transferred back to skilled nursing, when she fell over. They come over here usually because they need more help. I sometimes help the CNA to help her up because she is not a light person. She was supposed to be getting gait training I think in rehab therapy. The day when she fell in the therapy gym, I remember I passed medications for her, but she didn't appear weak though. I was actually surprised she fell because you would think therapy would be the safest place for a resident because they are there to get stronger."</p> <p>Efforts to reach R4's physician were met with no return calls.</p> <p>On 2/8/24 at 10:50 AM, V9 (NP) stated, I was seeing her routinely. I saw (R4) in the skilled area when she moved from the shelter area. She had bouts of pneumonia, we were treating her for an infection, a fever, and overall, she wasn't feeling well and so she was moved to skilled nursing. I was not directly informed of the incident. I was told her fall occurred the day her doctor was already in the facility. Surveyor asked if she was informed of any details of R4's diagnosis and hospitalization, V9 stated, "No I knew she was hospitalized but I wasn't informed she sustained a hip fracture, just now from you." Surveyor asked if she knew R4's overall functioning, V9 stated,</p>	S9999		

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6000046	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 02/08/2024
--	--	---	---

NAME OF PROVIDER OR SUPPLIER ADDOLORATA VILLA	STREET ADDRESS, CITY, STATE, ZIP CODE 555 MCHENRY ROAD WHEELING, IL 60090
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S9999	<p>Continued From page 11</p> <p>"From my understanding she was maybe contact guard assist to minimal assistance with transfers, and that was my understanding. My understanding from therapy notes was she was contact guard with supervision. She had a decline in her health, yes, and prior to this latest fall, I know that is the reason she transitioned to skilled nursing. I do recall that she had a fall while in the shelter area too. So I did a full work up after she moved to skilled area. She already had a fall, and she already had a fever, and so I can understand your rationale that she required a higher level of care. Surveyor asked if a resident were to have a change of condition where there was a decline in health that warranted transferring to the skilled nursing area, if that would require more than minimal assist and supervision, V10 stated, "I see what you mean about the resident requiring a level of care, so I do agree that she declined. As far as during therapy, other than contact guard assist, the resident probably would not have fallen had the therapist maintained her hold on the resident and not relied on the resident conducting the exercise herself, but I can't speculate on that because we weren't there."</p> <p>Hospital record reads in part, "Patient admitted to hospital on 2/1/24 with complaint of hip fracture after mechanical fall. Underwent ORIF (Open Reduction Internal Fixation surgery). Comminuted intertrochanteric fracture of the left femur status post Left hip ORIF, pain control, bowel regimen and DVT (Deep Vein Thrombosis) prophylaxis per ortho. Pain medications listed upon discharge: Oxycodone 5 mg. Take 0.5 tabs by mouth every 6 hours as needed for severe pain (pain scale 8-10); Tramadol 50 mg tab. Take 1 tab by mouth every 6 hours as needed for Moderate pain (pain Scale 4-7) Max Daily.</p>	S9999		

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6000046	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 02/08/2024
--	--	---	---

NAME OF PROVIDER OR SUPPLIER ADDOLORATA VILLA	STREET ADDRESS, CITY, STATE, ZIP CODE 555 MCHENRY ROAD WHEELING, IL 60090
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S9999	<p>Continued From page 12</p> <p>Policy dated 6/1/23 titled "Fall Prevention and Management Policy" reads in part, "A fall management program is 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. An evaluation of the factors also includes reviewing for previous falls, and if so, identifying any similarities. 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."</p> <p>(No violation)</p> <p>2 of 2</p> <p>300.610a) 300.1210b) 300.1210c) 300.1210d)1) 300.3220f)</p> <p>Section 300.610 Resident Care Policies</p> <p>a) The facility shall have written policies and procedures governing all services provided by the facility. The written policies and procedures shall be formulated by a Resident Care Policy Committee consisting of at least the</p>	S9999		

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6000046	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 02/08/2024
--	--	---	---

NAME OF PROVIDER OR SUPPLIER ADDOLORATA VILLA	STREET ADDRESS, CITY, STATE, ZIP CODE 555 MCHENRY ROAD WHEELING, IL 60090
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S9999	<p>Continued From page 13</p> <p>administrator, the advisory physician or the medical advisory committee, and representatives of nursing and other services in the facility. The policies shall comply with the Act and this Part. The written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, documented by written, signed and dated minutes of the meeting.</p> <p>Section 300.1210 General Requirements for Nursing and Personal Care</p> <p>b) The facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive resident care plan. Adequate and properly supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident.</p> <p>c) Each direct care-giving staff shall review and be knowledgeable about his or her residents' respective resident care plan.</p> <p>d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour, seven-day-a-week basis:</p> <p>1) Medications, including oral, rectal, hypodermic, intravenous and intramuscular, shall be properly administered.</p> <p>Section 300.3220 Medical Care</p> <p>f) All medical treatment and procedures shall be administered as ordered by a physician. All new physician orders shall be reviewed by the</p>	S9999		

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6000046	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 02/08/2024
--	--	---	---

NAME OF PROVIDER OR SUPPLIER ADDOLORATA VILLA	STREET ADDRESS, CITY, STATE, ZIP CODE 555 MCHENRY ROAD WHEELING, IL 60090
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S9999	<p>Continued From page 14</p> <p>facility's director of nursing or charge nurse designee within 24 hours after such orders have been issued to assure facility compliance with such orders. (Section 2-104(b) of the Act)</p> <p>These requirments are not met as evidenced by:</p> <p>Based on interview and record review, the facility failed to follow physician's orders to administer appropriate pain medications for a post- surgical resident experiencing extreme pain and failed to assess the severity of pain for 1(R4) of 4 residents reviewed for pain management in the sample. This failure resulted in R4 being unable to sleep due to extreme hip pain from post-surgical hospitalization for a hip fracture due to a fall sustained in the facility.</p> <p>Findings include:</p> <p>R4 is an alert and oriented 85 year old with diagnosis of pneumonia, muscle weakness, difficulty walking, and spinal stenosis.</p> <p>On 2/1/24 R4 was receiving continued strength training related to balance and gait issues due to a recent fall that occurred on 1/26/24. The resident, while receiving this therapy session had a mechanical fall leading to the emergent transfer to the hospital where the resident was diagnosed with left hip fracture with surgical intervention (Open Reduction Internal Fixation surgery).</p> <p>Hospital record reads in part, "Patient admitted to hospital on 2/1/24 with complaint of hip fracture after mechanical fall. Underwent ORIF (Open Reduction Internal Fixation surgery). Comminuted intertrochanteric fracture of the left femur status post Left hip ORIF, pain control, bowel regimen and DVT (Deep Vein Thrombosis) prophylaxis per</p>	S9999		

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6000046	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 02/08/2024
--	--	---	---

NAME OF PROVIDER OR SUPPLIER ADDOLORATA VILLA	STREET ADDRESS, CITY, STATE, ZIP CODE 555 MCHENRY ROAD WHEELING, IL 60090
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S9999	<p>Continued From page 15</p> <p>ortho. Pain medications listed upon discharge:</p> <p>On 2/4/24 at 6:31 PM, R4 was readmitted back to the facility after surgical operation and with orders for staple removal in 14-17 days. The physician order relayed to the facility included:</p> <ol style="list-style-type: none"> 1. Acetaminophen Oral Tablet 500 MG. Give 2 tablets by mouth three times a day for pain. Start date 2/4/24. 2. Tramadol HCL Oral Tablet 50 MG. Give 1 tablet by mouth every 6 hours as needed for pain (pain scale 4-7) Maximum Daily Amount 200 MG. Start date 2/4/24. 3. Oxycodone HCL Oral Tablet 5 MG. Give 0.5 tablet by mouth every 6 hours as needed for severe pain (pain scale 8-10) Maximum daily amount 10 MG. Start date 2/4/24. 4. Lidocaine External Patch. Apply to left hip pain topically one time a day for apply 6 AM and remove 6 PM. Start date 2/6/24. <p>On 2/6/24 at 1:00 PM, Surveyor visited the resident in her room to inquire about R4's hospitalization. R4 was seated in a wheelchair in her room with her daughter by her side. R4 was alert and was able to respond to questions appropriately and clearly provided by the surveyor. R4 stated, "I'm in a little bit of pain but fine now but I fell while V4 (PTA-Physical Therapy Assistant) was having me do exercises. She told me to get up from my wheelchair and I don't know what happened, but I just felt weak and all of a sudden I fell over to my left side and hit the floor really hard, and I was in a lot of pain. I think I might have yelled when I hit the ground but I can't remember because it went so fast." Surveyor asked when she received her pain medications, R4 stated, "I got them earlier, but when I first was admitted here, I had a horrible time. I couldn't sleep because I was in severe pain, and I could</p>	S9999		

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6000046	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 02/08/2024
--	--	---	---

NAME OF PROVIDER OR SUPPLIER ADDOLORATA VILLA	STREET ADDRESS, CITY, STATE, ZIP CODE 555 MCHENRY ROAD WHEELING, IL 60090
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S9999	<p>Continued From page 16</p> <p>not get the nurse to come in to give me my pain medications. I don't remember getting anything for my pain when I first got back from the hospital. I did not see a nurse to see how I was doing later that evening. I remember late at night pulling the call light so I could get something for pain. I remember somebody came in throughout the night, but I guess they may have forgotten about me, so I had to wait until the next day to get something for my pain." Surveyor asked if she recalled the nurse coming back after finally receiving her pain medication the next day to see if her pain was gone, R4 stated, "No, otherwise I would have asked for something stronger."</p> <p>Admission Assessment upon R4's readmission on 2/4/24 documented by V12 showed in part, "Have you had pain or hurting at any time in the last 5 days? Answer: Yes; How much of the time have you experienced pain or hurting over the last 5 days? Answer: Frequently; Over the past 5 days, has pain made it hard for you to sleep at night? Answer: Yes; Over the past 5 days, have you limited your day-day activities because of pain? Answer: Yes; Verbal Descriptor Scale for over the last 5 days.: Answer: Severe."</p> <p>On 2/7/24 at 11:30 AM, Surveyor asked V2 (DON-Director of Nursing) how the facility managed pain for their residents, V2 stated, "As far as reassessment, we assess for pain by seeing if there is grimacing and guarding, visualization, if the resident is not eating, resistance to care, and we get the resident's pain level to see if they have a PRN (as needed) medications, and if they are showing symptoms of pain, we give the PRN, then monitor and reassess. Often times we take the vitals." Surveyor asked about R4's pain medication regimen when the resident returned from the</p>	S9999		

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6000046	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 02/08/2024
--	--	---	---

NAME OF PROVIDER OR SUPPLIER ADDOLORATA VILLA	STREET ADDRESS, CITY, STATE, ZIP CODE 555 MCHENRY ROAD WHEELING, IL 60090
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S9999	<p>Continued From page 17</p> <p>hospital on 2/4/24, V2 stated, "(R4) was readmitted in the afternoon on 2/4/24 which was a Sunday by V12 RN, and it looks like nothing was given until the following day Monday the 5th at 3:09 PM by V13</p> <p>Efforts to contact both V12 (RN) and V13 (LPN) were met with unreturned voice messages.</p> <p>Review of R4's MAR (Medication Administration Record) showed on 2/4/24, no pain medications were provided to the resident including the patient's scheduled Tylenol when R4 came back to the facility in the afternoon, and no pain medications throughout the evening and early morning the next day which prevented R4 from sleeping.</p> <p>On 2/8/24 at 10:50 AM V9 (NP) was asked about pain management, V9 stated, "They should assess in general at least every shift and documenting where the pain is, on the rating scale, to see what pain medication is available, and to provide that specific medication as it relates to the pain rating the resident provides the nurse. There's also other measures like repositioning." Nurses should have to reassess the resident and/or provide other techniques to see if it was effective. If the patient says they're in pain, then this should have been addressed to relieve the patient's discomfort. Surveyor asked about R4's post surgically prescribed pain medications and how nurses should treat pain in regards to post surgical pain, V9 stated, " Like any pain, it should have been addressed. What the pain rating was, if medication is needed (etc.), but yes the order should be followed as ordered."</p> <p>Policy dated 6/1/23 titled "Pain Management" reads in part, "The community to the extent</p>	S9999		

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6000046	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 02/08/2024
--	--	---	---

NAME OF PROVIDER OR SUPPLIER ADDOLORATA VILLA	STREET ADDRESS, CITY, STATE, ZIP CODE 555 MCHENRY ROAD WHEELING, IL 60090
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S9999	<p>Continued From page 18</p> <p>possible to prevent or manage pain will: 1. Recognize when the resident is experiencing pain and identifies circumstances when pain can be anticipated. 2. Evaluate the existing pain and the causes and 3. Manage or prevent pain, consistent with the comprehensive assessment and plan of care, current professional standards of practice, and the resident's goals and preferences. Assessment: The nursing staff will evaluate each individual for pain upon admission to the community, at the quarterly review, whenever there is a significant change in condition, and when there is onset of new pain or worsening of existing pain. Staff will evaluate pain using the pain review in point click care. Cause Identification/Treatment: The physician will help identify causes of pain by examining the resident directly, reviewing the resident's history, and via discussion with the resident and staff. For example, a hospital discharge summary may indicate that the resident has a painful condition or was receiving medications that may cause or exacerbate pain. The physician will order appropriate medication interventions to address the individual's pain. Pain medications should be selected based on pertinent treatment guidelines. The staff will evaluate and report how much and how often the individual asks for PRN pain medication."</p> <p>(B)</p>	S9999		