

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0045443		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 03/27/2026	
NAME OF PROVIDER OR SUPPLIER ADDOLORATA VILLA				STREET ADDRESS, CITY, STATE, ZIP CODE 555 MCHENRY ROAD , WHEELING, Illinois, 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) COMPLETION DATE
S0000	Initial Comments Complaint Investigation Survey 2693113/ 2804148			S0000			
S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.1210b) 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 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. 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: 6) All necessary precautions shall be taken to assure that the residents' environment remains as free of accident hazards as possible. All nursing personnel			S9999			

Office of Primary Care and Health Systems Management

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE		TITLE	(X6) DATE
---	--	-------	-----------

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0045443		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 03/27/2026	
NAME OF PROVIDER OR SUPPLIER ADDOLORATA VILLA				STREET ADDRESS, CITY, STATE, ZIP CODE 555 MCHENRY ROAD , WHEELING, Illinois, 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) COMPLETION DATE
S9999	Continued from page 1 shall evaluate residents to see that each resident receives adequate supervision and assistance to prevent accidents. These requirements are not met as evidenced by: 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,			S9999			

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0045443		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 03/27/2026	
NAME OF PROVIDER OR SUPPLIER ADDOLORATA VILLA				STREET ADDRESS, CITY, STATE, ZIP CODE 555 MCHENRY ROAD , WHEELING, Illinois, 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) COMPLETION DATE
S9999	Continued from page 2 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 12/1/2025 Subject: Fall Prevention & Management Policy Policy: 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. (A)			S9999			