STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6000046	A. BUILDING: _____ B. WING _____	C 08/25/2023

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

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S 000	Initial Comments Facility Reported Incident Investigation IL162978 of 8/3/23	S 000		
S9999	Final Observations Statement of Licensure Violations: 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 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	S9999	**Attachment A** **Statement of Licensure Violations**	

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S9999	Continued From page 1 resident to meet the total nursing and personal care needs of the resident. c) Each direct care-giving staff shall review and be knowledgeable about his or her residents' respective resident care plan. 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 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 supervise/monitor a resident identified to have a lack of safety awareness. This affected one of three residents (R1) reviewed for supervision and fall prevention. This failure resulted in R1 having a fall incident and sustaining a left intertrochanteric femur fracture. The findings include: R1's diagnosis include but are not limited to Supraventricular Tachycardia, Hyperlipidemia, Dementia, Depressive Disorder, Alzheimer's Disease, and Osteoarthritis. On 8/22/23 at 11:08AM R1 observed in her bed resting and did not acknowledge the surveyor. On 8/22/23 at 12:00PM V1, Dining Services, said	S9999		

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S9999	Continued From page 2	S9999		

there had been an activity in the dining room on 8/3/23 and it was over so she and V2, Dining Services, were setting up for the meal. V1 said only herself, V2, and R1 were in the room. V1 said R1 was sitting in a chair near a table. V1 said I had never met R1 before. V1 said we were left about 15 minutes with R1 in the dining room. V1 said when we walked in there was no staff in the room. V1 said in her department she tries to keep an eye out for all the residents, and she can tell someone to sit down. V1 said she saw R1 was trying to scoot herself up and V1 said I told her to sit down and that someone was coming for her. V1 said R1 was lifting her bottom by using the arm rest on the chair to lift herself. V1 said when I turned back to R1 she was on the ground, V1 said my back had been turned towards R1. V1 said I did not see when R1 stood up from the chair before she fell. V1 said R1 was wondering and asking who was coming back to pick her up. V1 said R1's wheelchair had rolled away from her when she fell.

On 8/22/23 at 12:08PM V2, Dining Services, said on 8/3/23 I was in the dining room doing my duties. V2 said I overheard V1 tell R1 to sit down and then I saw R1 on the floor. V2 said I stayed with R1 while V1 went to call for help. V2 said R1 was holding her side and saying ow. V2 said the activity staff were not in the dining room. V2 said she was in the dining room with V1 and R1 about 20 minutes before R1 fell. V2 said R1 was asking about going back to her room. V2 said my back was turned towards R1 and when I turned back to look R1 was falling, V2 said R1 stood up and was trying to bend, and then she was laying on her side on the floor.

On 8/22/23 at 12:35PM V3, Life Enrichment Aid, said she had left the dining room on 8/3/23 and

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S9999	Continued From page 3	S9999		

when she returned R1 was on the floor. V3 said when I left the room V4, Life Enrichment Aid, was in the room with R1. V3 said when Life Enrichment Aids do an activity someone has to stay with the residents during and after the activity to keep them supervised. V3 said when I came into the dining room only the dining staff were in the room, and I stayed with R1. V3 said R1 was laying completely on the floor. V3 said R1 has a history of trying to get up unassisted, if you leave her alone. V3 said R1 needs help to come to the dining room from her room, on the second floor, and she would need assistance to move her wheelchair. V3 said the practice is not to leave residents unattended.

On 8/23/23 at 10:00AM V8, Administrator said the fall incident reports are internal documents and were not provided to the surveyor to review.

On 8/23/23 at 10:10 AM V5, Nurse, said on 8/3/23 I was called to see R1, and they said she was on the floor in the first floor dining room. V5 said the activity staff had taken R1 to the activity earlier in her wheelchair. V5 said before the fall R1 has Dementia and is very confused. V5 said R1 cannot walk by herself or get up alone. V5 said R1 has fallen before. V5 said fall risk residents are those with dementia diagnosis, memory problems, and if a fall risk while in the hospital. V5 said we report verbally to staff to let them know who a fall risk resident is. V5 said R1 does not remember what happened that day when she fell. V5 said R1 had surgery after the fall on 8/3/23.

On 8/23/23 at 10:30AM V6, Certified Nursing Assistant (CNA), said R1 is confused, needs reminders, and sometimes she does not understand. V6 said R1 will not understand a

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verbal direction. V6 said when R1 is in her room, she will try to get up and calls out. V6 said R1 needs physical cues/contact to sit down. V6 said R1 will not just sit if told because she tries to get up. V6 said R1 is often calling out and asking for her son if she does not see him (R1 shares a room with her son.)

On 8/23/23 at 10:45AM V4, Life Enrichment Aid, said on 8/3/23 the activity ended, and I took R4, R1's son, to the second floor and I left R1 on her own. V4 said on my way back to the dining room I heard code purple and I saw R1 on the floor when I got there. V4 said I was not supposed to leave R1 alone because R1 can't control herself. V4 said I left R1 because I thought I would be back quick. V4 said after an activity we usually stay to supervise a resident. V4 said we don't leave kitchen people in charge of the residents.

On 8/23/23 at 11:15AM V9, Director of Nursing, was asked to review the fall incident reports with the surveyor since they were not provided for review. V9 discussed R1's incident report. V9 said on 6/20/23 R1 got up unassisted from her wheelchair after dinner and fell. V9 read the findings and said R1 has a behavior of following her son (R4) when he leaves the room. V9 said R1 tried to get up and follow R4 and R1 fell. V9 said on 8/3/23 she arrived to R1's side once notified R1 had a fall. V9 said R1 was saying "I gonna stand up." V9 read off the predisposing factors: has gait imbalance, impaired memory, and confused. V9 said R1 has Dementia, and she may not get it if a verbally instruction is given to her one time. V9 said R1 was sent to the hospital for evaluation and was found to have a left femur head fracture. V9 said V1 and V2 should have been trained on Purposeful Rounding. V9 said staff should know if a resident is in a wheelchair,

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they should think they are at risk for falls. V9 said everyone is at risk for falls. V9 said I would expect them (staff) to approach the resident and say stay here and calm the resident. V9 was asked what her expectation is if nonclinical staff see a resident trying to get up unassisted. V9 said I would expect staff to stay with the resident and wait until someone from activity returned.

On 8/23/23 at 1:01PM V7, Dietary Manager, said Purposeful Rounding is a facility program developed to monitor residents. V7 said V1 and V2 could be assigned to rounding, but they work on the Assisted Living unit and rounding is focused on the long term care side. V7 said V1 and V2 will set up in the dining room for meal services. V7 said dietary staff seldom interact with long term care residents. V7 said the expectation of the dietary staff is to address the resident verbally, communicate the behavior, and control the situation. V7 said dietary staff are not to touch the residents because they are not clinically trained.

On 8/23/23 at 1:23PM V8 said we do not have a policy for supervision. V8 said fall prevention is an interdisciplinary team approach, everyone is responsible. V8 said all departments have been educated on fall prevention. V8 said if the resident is displaying these behaviors (i.e., attempting to get up) then staff should try to stop it and call for help.

R1 has diagnosis including but not limited to Dementia, Major Depressive Disorder, Alzheimer's Disease, and Osteoarthritis.

R1's Fall Scale dated 6/23/23 indicates a score of 55. R1 has fallen before. R1 overestimates or forgets limits. Scoring indicates a High Risk 45

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S9999	Continued From page 6 and higher. R1's progress notes dated 6/26/23 notes R1 educated on fall precautions. R1 had unwitnessed fall on 6/21/23 and sustained left superior pubic rami fracture. R1's progress notes dated 7/10/23 states fall prevention in place. R1's progress notes dated 8/3/23, written by V5, sates R1 complained of left hip and left lower back pain... Progress note written by V9 states R1 admitted for left femur head fracture. IDPH report notes R1 is alert and orientated times 1, her cognitive score is 2. Facility provided witness statement from V3 typed and initialed by V3 states V3 told V4 to stay in the room until she returned from taking another resident to another location. V3 responded to a question on her statement saying there has to be someone with them (residents) at all times. If I see I am the last one, I stay until someone else comes in. V3 states she is aware R1 is a high fall risk. V3 said I have been with her (R1) when she tries to stand up and she needs to be reminded to sit down. Facility provided witness statement from V4 typed and initialed by V4 states we started to take residents back to their rooms. We cannot leave the residents alone. V4 left to take R4 to his room. V4 said he left R1 in the dining room and the dining staff was there. V4 stated I did not tell them I was leaving. V4 stated I was not supposed to leave the room, but I thought it would be quick. V4 said he is aware of who is a high fall risk resident, if they are in a wheelchair, they are most likely a fall risk.	S9999		

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S9999	Continued From page 7 R1's care plan initiated on 3/28/23 states R1 usually (does not mean always) able to understand others. Care plan further states R1 has a behavior of following her son who shares a room with R1. R1 without safety awareness, tries to ambulate without assistance when her son is not in her sight. Intervention dated 6/26/23 states son is encouraged and educated to request assistance for his mom (R1) before exiting the room. (R1's son is R4, resides in the facility.) Hospital record dated 8/3/23 states Imaging Xray of the pelvis and femur show left intertrochanteric femur fracture. Assessment states fracture due to fall and osteoporosis. Plan Open Reduction Internal Fixation of left intertrochanteric femur fracture. Facility system policy Fall Prevention and Management dated 6/1/23 states Supervision- The community will provide adequate supervision to prevent accidents. Type and frequency will be based on individual assessed needs and identified hazards in the resident environment. (A)	S9999		