STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6008247	A. BUILDING: _____ B. WING _____	07/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROSARY HILL HOME	9000 WEST 81ST STREET JUSTICE, IL 60458

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Z 000	COMMENTS Annual Licensure Survey	Z 000		
Z9999	FINDINGS Statement of Licensure Violations: 300.610 a) 300.690 b) 300.1210 b) 300.1210 d)6) 300.1220 b)3) 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. 300.690. Incidents and Accidents b) The facility shall notify the Department of any serious incident or accident. For purposes of this Section, "serious" means any incident or accident that causes physical harm or injury to a resident. 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	Z9999		

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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 shall evaluate residents to see that each resident receives adequate supervision and assistance to prevent accidents.

300.1220. Supervision of Nursing Services
b) The DON shall supervise and oversee the nursing services of the facility, including:
3) Developing an up-to-date resident care plan for each resident based on the resident's comprehensive assessment, individual needs and goals to be accomplished, physician's orders, and personal care and nursing needs. Personnel, representing other services such as nursing, activities, dietary, and such other modalities as are ordered by the physician, shall be involved in the preparation of the resident care plan. The plan shall be in writing and shall be reviewed and modified in keeping with the care needed as indicated by the resident's condition. The plan shall be reviewed at least every three months.

These requirements are not met as evidenced by:

Based on interview and record review, the facility to develop an effective fall interventions; failed to

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provide effective monitoring to prevent a fall for a resident identified to be high risk for ; and failed to notify the Department within 5 days of a serious injury. As a result of these failures, R1 was observed on the floor laying on her right side, experiencing pain, sent to hospital, and evaluated and treated for broken right arm and broken right hip. This affects one of five residents reviewed for supervision.

Findings include:

R1 was observed awake and alert, able to make her needs known for pain. R1 is not available for interview due to medical concerns.

R1's profile/face sheet shows diagnosis of Parkinson, anxiety, and pressure ulcer.

R1 plan of care, dated 4/14/25, denotes potential for injury related to impaired safety awareness, history of 3 falls before coming here 9/2023, arthritis with painful joint, weakness, Parkinson's disease. As evidence by weakness, physically frail, and impaired mobility. Resident will remain free from any falls or injuries through next review 6/17/25.

R1's plan of care does not address the use of wheelchair on or before 5/9/25 and does not address or a plan on how to monitor R1 and keep R1 from falling out of wheelchair prior to 5/9/25.

Review of the facility initial report, dated 5/9/25, and final report, dated 5/10/25, shows no documentation denoting R1 injuries of broken arm and broken hip.

R1's fall risk assessment, dated 5/10/25, shows fall score of 18 high risk. Fall risk assessment

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denotes fall on 4/14/25. No fall risk score noted for fall on 4/14/25.

R1's progress notes, dated 5/10/25 at 2:25pm, completed by V9, denotes, "POA (Power of Attorney) called with update and resident, resident broke her hip and arm of the right side. She is after hip surgery and waiting until Monday for arm surgery. According to POA resident will stay in hospital next week and then will be discharged to rehab. We will continue to monitor."

R1's hospital records documents, "patient is 73-year-old female past medical history of Parkinson disease dementia, DVT (deep vein thrombosis), orthostatic hypotension, and recurrent falls who is presenting with falls arm pain hip pain. Presenting from nursing home. EMS (Emergency Medical Services) reporting patient failed the other day at the nursing home onto her left side. At that point there was some concern for hip pain, but she was not evaluated. She then fell again today onto her right side and has severe right pain with deformity. Unclear exact circumstances around falls nursing home reported that they were mechanical and that she has recurrent falls from her Parkinson's disease. Patient had significant pain and unable to provide additional history. She was reporting pain in her right arm her back and her bilateral hips. CT (Computed Tomography) impression, there is an acute fracture of the proximal femur intertrochanteric region with varus deformity. X-ray humerus, impression, acute transverse fracture of the right humerus diaphysis at the tip of the humeral stem. This is displaced posterolateral one bone width with apex anterior angulation and foreshortening."

On 7/17/25 at 12:50pm, V2 (Director of Nursing)

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said R1 had a fall, resulting in a broken right arm and a broken right hip. V2 said R1 had surgery to both areas. V2 said the fall happened in May 2025. V2 said the Department was notified of the fall, but was not notified of the injury. V2 explained their reporting policy directs them to send the final report to the Department within 24 hours of an accident or incident. V2 explained the facility did not know of R1's injury until after they sent the final report to the Department. V2 said maybe the facility should have made an addendum to the final report that was sent to the department and reported R1's injuries.

On 7/18/25 a 1:00pm, V8 (Certified Nursing Aide) said herself and (V10) (Certified Nursing Aide) were monitoring the dining room on the first floor. V8 said this was the morning 5/9/25. V8 said she left the dining room to check on another resident that was having declining health. V8 said she left V10 in the dining room. V8 said she heard V10 say something, so she returned to the area of V10 voice. V8 said as she approached the dining room, R1 was observed laying on the floor on her right side. V8 said V10 was visibly upset, and V10 said she left the dining room to get R1 some towels; she was gone less than 5 minutes. V8 said she announced code white to summon the Nurse. V8 said R1 said she was reaching for the flower vase that was on another table in the dining room when she fell. V8 said R1 wheelchair was still in the locked position, but it was away from the table that R1 was sitting at prior to her leaving the dining room. V8 said she doesn't know how R1 got up from the chair. V8 said R1 does move quickly if you are not watching R1. V8 said R1 has to be monitored because she is a fall risk.

On 7/18/25 at 1:28pm, V9 (Registered Nurse/RN)

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said responded to the dining room after staff announced a code white. V9 said she observed R1 on the floor laying on her side. V9 said 911 was summoned, physician was notified. V9 said the paramedics removed R1 from the floor, but before the removed her they placed a sling on R1's right arm. V9 said she stayed there the entire time paramedics assessed R1. V9 said she not sure if the paramedics observed any deformities to R1's arm at that time, but they did place a sling on R1's arm. V9 said R1 daughter called her on 5/10/25 after 2pm, and made her aware R1 had hip surgery and R1's right arm was broken and R1 was awaiting orthopedics to determine the plan of treatment. V9 said she notified the Administrator (V1) of R1's injuries. V9 said the aide was only gone less than five minutes and R1 fell. V9 said, "(R1) has to be monitored while in the dining room; (R1) is fall risk. (R1) had multiple falls at home."

On 7/17/25 2:48pm, V2 (Director of Nursing) said R1 has to be monitored when in the dining room because R1 is a fall risk.

On 7/18/25 at 1:30pm,cV10 (CNA-Certified Nursing Aide) said she and V9 left the dining room on 5/9/25. V10 said she was getting towels for R1 shower, and V9 was checking on a resident that put on call light, that was having a decline in health. V10 said R1 is a fall risk; she was not aware of previous fall at the facility for R1. V10 said R1 has dementia and Parkinson's. V10 said getting towels for a shower and checking on a resident with declining health is equally important. V10 agreed R1 should not have been left alone; R1 has dementia and may not be aware that if she gets up from the wheelchair that she can fall and sustain injuries.

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Z9999	Continued From page 6 Review of facility incident/ accident protocol for residents, last revised date 11/20/2022, denotes, facility will use Rosary hill forms incident report forms to notify IDPH (see appendix A), preliminary 24-hour investigation report (see appendix B). Appendix B denotes in-part This report should be mailed or faxed during regular office hours to the department of public health. This report should be mailed for faxed within 24 hours of the incident. A final investigation report will be sent to the department of public health within five working days. (A)	Z9999		