STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6007892	A. BUILDING: _____ B. WING _____	C 06/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASCENSION RESURRECTION PLACE	1001 NORTH GREENWOOD AVENUE PARK RIDGE, IL 60068

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S 000	Initial Comments Facility Reported Incident of 5/24/24/IL174055	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. 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.	S9999		

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S9999	Continued From page 1 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 were not met as evidenced by: Based on interview and record review, the facility failed to adequately supervise one (R2) resident at risk for falls, a total assist resident and dependent on staff supervision/assistance with all ADL's (Activities of Daily Living); failed to provide assistive device of foot rests on a geriatric wheelchair to prevent sliding/falling; and failed to maintain functionality of bed in order to lower close to the ground. This failure affected one resident (R2) of 9 residents reviewed for accidents/hazards/supervision and resulted in R2 being transferred to the emergency department after a fall from a geriatric wheelchair and diagnosed with a right tibial fracture; and transferred again 11 days later to the emergency department after another fall from a malfunctioning bed. Findings include:	S9999		

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R2 is a 80-year-old-male with diagnoses including but not limited to hemiplegia, diabetes, neoplasm of prostate, and epilepsy.

On 6/11/24 at 10:30 AM, V2 (director of nursing) stated that on 5/23/24 at 2:00 PM, R2 was in the dining area attending an activity program when R2 slid down from his high-back geriatric chair and bent/twisted his right leg in the process. According to interview on 6/11/24 at 10:50 AM with V3 (activity aide), V3 did not see R2 slide down because V25 (CNA) in charge of monitoring R2, left the dining area at the time of the incident. V3 called for help and two CNAs (V4, V6) came to lift the resident back up from the geriatric chair.

Per V4 (CNA) and V6 (CNA) R2 was supposed to have leg rests on his wheelchair which would have prevented the resident from sliding down, however there were no leg rests that were attached as they should have been. The nurse on duty at the time (V8-RN), assessed R2 but did not report the incident of a fall because at the time, V8 did not consider the incident a fall. The following day, V7 (CNA) reported to the nurse on duty that R2 had pain and swelling on the right knee so the resident was sent to the emergency department for evaluation where he was diagnosed with the tibial fracture.

On 6/5/24, R2 was found on the floor beside his bed at 4:50 AM but was last observed in bed at 2:50 AM sleeping.

On 6/12/24 at 11:50 AM, V2 (director of nursing) stated, "(R2)'s second fall on 6/5/24 happened on the night shift when the nurse (V29) found him on the floor on kneeling position. According to the 3-11 shift CNA (V30), around 4:15 PM, V30

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noticed the remote was not working on the bed so V30 could not lower the bed to the lowest position. V30 told the nurse (V29) but didn't do anything about it. The next day V29 was no call-no show and quit." Regarding the bed functioning properly, V2 stated, "We're supposed to keep his (R2) bed in the lowest position to keep him safe and (V29) knew that. She (V29) should've informed someone that the bed was not working because otherwise (R2) may not have fallen from the bed."

Interviews of staff are as follows:

On 6/11/24 at 10:30 AM, V2 (director of nursing) stated, "(R2) was in the dining room attending an activity when one of the residents alerted the activity aide (V3) that the resident was on the bottom of the reclining chair. He (R2) slid there but it is still considered a fall. On 5/23/24 at 2:00 PM was when the activity was going on. V8 (RN) was the nurse but did not report this as a fall because she thought because the resident did not hit the ground that it wasn't a fall. I in serviced her (V8) about falls after this. So, the 3-11 shift nurse was not aware of any bruising that day until the night shift CNA (V7) reported to the nurse the next morning that she saw swelling on the resident. The resident's (R2) leg was under his right leg, and it got bent or caught somewhere. If there was a foot rest that could have prevented him from sliding down."

On 6/11/24 at 10:50 AM, V3 (activity aide) stated, "(R2) is one of our residents that goes to activities, and he does not walk and only uses his left hand. He is on a recliner chair. He comes to activities by a CNA bringing him to the activity room. He is very friendly to staff and does not have any behaviors. He is slightly confused. He's

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Spanish speaking only. So, when he fell, I was doing activities and one of the residents called out to me and said that (R2) is sitting near the foot of his recliner chair and his right foot was angled like a figure four and it was under his left knee. The CNA that was supposed to be monitoring the residents left the room when R2 fell, and she was supposed to stay there or get someone else to watch if she had to leave." Surveyor asked how many residents were attending the activity at the time, V3 stated, "It was around 25 residents."

On 6/11/24 at 11:45 AM, V4 (CNA) stated, "I came to the dining room where they were having activities and V6 (CNA) called me over to help get a resident back up from his recliner. She (V6) told me the patient (R2) was near the ground, so I helped boost him back up. His leg was twisted under his other leg and looked like it got caught under the chair and he didn't have a leg protector or leg rest on him form keeping him from sliding which he should have had. We told the nurse what happened, and she came and assessed the resident (R2)."

On 6/11/24 at 11:50 AM, V6 (CNA) stated, "I was not (R2)'s aide that day, I was just the one helping (V4-CNA) pull the resident up. His leg was bent because he slid down to the bottom of this recliner chair. He didn't have a foot rest, so he slid down and he got his leg caught from under the chair. " Surveyor asked V6 to accompany surveyor to R2's room to look at the chair used. V6 pointed to the recliner which appeared more like a high back wheelchair. V6 pointed to the foot rest now resting on top of the chair. V6 stated, "That was not on the chair at the time we scooted him up from the bottom of the chair and it should have been put there otherwise

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he wouldn't have slid down and bent his leg."

On 6/12/24 at 10:55 AM, V8 (RN) stated, "(R2) was sitting in the dining room around after 1:00 PM but I was on my break when the activity aide (V4) came and told me that the resident slid down on his knees to the reclining chair with his right knee bent backward. I assessed the patient and checked for pain, redness or edema. (R2) nodded he was in pain, so I gave Tylenol. We took him with mechanical lift to bed, but I didn't notify anyone that it was a fall, but I know now it was because the DON (V2) told me. Later on, the morning time the night shift found edema on the resident so they called the doctor and so they sent the patient out to the hospital, and they found the right leg or ankle was fractured. He came back. he was non weight bearing. He was total assist, but he was a low fall risk." Surveyor asked what fall preventative measures were taken to keep R2 safe, V8 stated, "We do the rounds, and we keep him in bed at the lowest position and checking on the patients' needs. He's incontinent and knows how to pull the call light. He's nonverbal and alert and oriented times two. (R2) came back from the hospital after 4 or 5 days in the hospital then he fell from the bed because the bed could not be lowered, I guess due to mechanical failure I was told."

On 6/12/24 at 12:05 PM, V25 (CNA) stated, "He's (R2) very quiet patient and he is a 2-person assist with a mechanical lift. He needs help with feeding and incontinence, and right sided paralysis. We get him up every day on recliner chair. I put him in the dining room, but he was not a fall risk. I was supposed to be in dining room watching the residents, but I had to help another CNA, so I left, but I should have asked somebody to come to sit and watch."

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S9999	Continued From page 6 Hospital record dated 5/24/24 12:53 PM, written by Emergency room doctor (V26) reads in part, "(R2) is a 72 year old male who is being seen for right leg pain. Per nurse, he is confused at baseline. He is Spanish speaking. He lives at nursing home and was brought here for evaluation of his right leg. It is currently in a post mold. Indication: trauma (fracture). Findings: Comminuted fractures of the proximal tibia and fibula are identified." Hospital record for the second fall and emergency room visit dated 6/5/24 reads in part, "Patient is a 72 year old male presenting to the emergency department from a musing home after being found down. Per EMS patient is currently at his baseline. Patient mumbles, does not answer questions, does not follow commands. No acute intracranial process or significant interval change when compared to prior CT head dated 5/24/24 (previous admission). Stable subdural hematomas bilaterally, right greater than left." Policy revised on 7/2023 titled "Fall Prevention" reads in part, "The intent of this policy is to provide an environment that is free form accident hazards, over which there is control, and provide supervision and intervention to residents to prevent avoidable accidents. Residents shall be evaluated by a licensed nurse during the admission process, routinely and as indicated to identify potential risk of fall. The interdisciplinary team shall identify individualized interventions to reduce the risk of falls." (B)	S9999		