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 _____	05/02/2024

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 Annual Licensure Survey	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 (R73) resident who has a history of falls and required staff supervision/assistance with all Activities of Daily Living (ADLs). This failure affected one resident (R73) of seven residents reviewed for accidents and resulted in R73 being diagnosed with a displaced nasal bone fracture. Findings include: R73 is a 62-year-old- female who was admitted to the facility on 3/06/2023. Past medical history includes, but not limited to, progressive supranuclear, dystonia, hyperlipidemia, unsteadiness on feet, need for assistance with personal care, anxiety, essential primary hypertension, etc.	S9999		

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R73 has had three falls since January 2024. On 1/16/2024, R73 had an unwitnessed fall while at the nursing station. On 2/16/2024, R73 was found face down while at the nursing station and sustained some injuries on both knees, fall was unwitnessed. On 3/10/2024, R73 was found on the floor in activities room, was sent to the hospital and was treated for a minimally displaced nasal bone fracture.

On 4/29/2024, R73 was observed in her room, awake and alert, but unable to answer any questions. Bilateral floor mats noted in the room. Oxygen concentrator noted at bedside but not connected toR73. No broader chair or Geri-chair noted in the room.

On 4/30/2024 at 9:50AM, R73 was observed again in bed on a concave mattrass. R73 was lying on her back with floor mats on the floor. There was no wheelchair, broader chair or Geri chair noted inR73's room.

Fall care plan dated 3/26/2023 stated R73 is at risk for fall related to decreased safety awareness. Interventions include closely monitor when in room, offer her to sit in recliner after lunch (6/24/2023), try to keep near nurses' station and keep her involved in things she likes. Minimum data set assessment (MDS) section GG (functional status) indicated R73 requires partial/moderate assistance to substantial/ maximal assistance from staff for all ADL needs. MDS section C: 2/6/2024 BIMS - 10 indicating cognitive impairment.

Facility reported incident dated 3/15/2024 documented R73 was found on the floor on 3/10/2024 at 2PM. Upon head-to-toe assessment, R73 was having nose bleeding, first

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aid was provided, andR73 was sent to the emergency room and returned to the facility with a diagnosis of nose fracture, facility started an investigation. CT facial bones without contrast from the hospital dated 3/10/2024 showed a minimally displaced nasal bone fracture. Review of all staff statements indicated that no one witnessed the fall except the activity aide.

On 05/01/24 at 11:25 AM, surveyor observed R73 in bed with the assigned nurse and V12 (R73's POA) at the bedside. V12 stated, she is usually at the facility every day and has a lot of issues with the care the R73 is receiving. V12 (POA) said, R73 had so many falls because the facility always put her in the activities room or the nursing station. V12 said, R73 likes to stay in her room and watch TV, but facility stated they do not have enough staff to watch her, and they do not provide 1:1 supervision. V12 said, she has consistently asked the facility to put R73 in a broader chair when she is out of bed instead of a regular wheelchair. The facility provided a broader chair for a while, and it disappeared. V12 said, the last fall R73 had with a nose fracture happened because the staff in activities room did not want to watch R73 and told the nurse to take R73 with her. V12 said the facility stated R73 jumped out of her wheelchair but R73 has unsteady feet and weakness in her lower extremity and there is no way she can jump out of her chair.

On 05/01/24 at 2:33 PM, V2 (DON) said she is familiar with R73. R73 is unsteady, a high fall risk and requires 24 hours seven days a week 1:1 supervision. V2 said, one of the interventions the facility has in place for R73 is for her to be monitored closely. R73 is always at the nursing station or activities, but for some reason, R73

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always falls when the staff is not looking. V2 said "The staff can turn around and the next thing, R73 is on the floor". V2 added, R73 is not able to jump out of her wheelchair but tries to slide out of her chair.

On 5/2/2024 at 10:13AM, V19 (C.N.A) said that she is familiar with R73, she is calm and sometimes tries to crawl out of bed. V19 said R73 is a fall risk and requires constant supervision. V19 stated R73 had three different fall incidents on 3/10/2024. The first time she slid out of her wheelchair to the floor while in the hallway. The second time, an activity staff saw R73 slid out of her wheelchair to the floor while at the nursing station and the third time R73 was found in the floor face down in the dining room. V19 added R73 was in a regular wheelchair for all the three incidents.

On 05/02/24 at 10:26AM, V16 (Activity aide) said, she was in the activity room on 3/10/2024 when R73 fell and sustained an injury. V16 was watching R73 in activity and told the nurse that V16 could not watch R73. V16 said the nurse was leaving the room, R73 followed the nurse in her wheelchair and before V16 could reach R73, she fell face down from her wheelchair. V16 added, there were 20 to 25 residents in the activities room, and V16 cannot watch all of them.

Fall policy provided by V2 (DON) with a revision date of 01/2026 states in its policy statement that the purpose of this procedure is to provide guidelines for evaluation of a resident in the event a fall occurred and to assist associates in identification of potential causes of the fall. Under policy details, the document states in part that the fall risk assessment form (or similar fall risk evaluation) should be utilized to complete the

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S9999	Continued From page 5 evaluation of the resident's potential for falls during the admission process. A licensed nurse shall observe clinical status for 72 hours after an observed or suspected fall, and document findings in the resident's clinical record. The falls should be reviewed at the daily stand-up meeting following the fall for identification of additional individualized interventions to reduce the risk of falls. (B)	S9999		