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 12/26/2024

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

(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) COMPLETE DATE
S 000	Initial Comments Complaint Investigation 24910175/IL182466	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.1210b) 300.1210d)3) 300.3240a) 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	S9999		

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:

3) Objective observations of changes in a resident's condition, including mental and emotional changes, as a means for analyzing and determining care required and the need for further medical evaluation and treatment shall be made by nursing staff and recorded in the resident's medical record.

Section 300.3240 Abuse and Neglect

a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. (Section 2-107 of the Act)

These requirements were not met as evidenced by:

Based on interview and record review, facility staff V3 (Certified nursing assistant, CNA) failed to report a fall to the nurse for one resident (R2). This failure resulted in R2 being transferred back into bed with no nurse assessment for over 10 hours. R2 was transferred to the hospital for a left ear laceration requiring eleven sutures and broken ribs for one of three residents reviewed for falls.

Findings include:

R2 was admitted to the facility on 12/6/24 with a diagnosis of Covid 19, urinary tract infection, Parkinson's and overactive bladder. R2 Minimum data set dated 12/11/24 documents R2 required substantial/maximal assistance (helper does more than half the effort) with sit to stand, chair to

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S9999	Continued From page 2	S9999		

bed transfer, and toilet transfers.

R2's fall risk assessment dated 12/6/24 documents: R2 is moderate risk for falls.

On 12/26/24 at 3:37PM, V21(former unit manager) said R2 was alert and oriented with periods of confusion. V21 said she went to R2's room around 4:00pm per family's request and daughter showed her R2's ear which had a cut. V21 said she asked R2 what happened and R2 reported the same story 3 different times, that she fell in the middle of night around 1-2 AM. R2 said she was trying to get water and fell. R2 said she hit her head hard on something but unsure what. R2 said a male staff member picked her up and put her back in bed. R2 reported that same male staff told her she did not need a nurse.

On 12/26/24 4:26PM, V2 (Director of nursing, DON) said family wanted to speak to V2 about a cut on R2's ear around 4:00PM on 12/11/24. R2 reported she was thirsty and wanted water that was on the bedside table around 1-2AM. R2 said she spilled the water, got up from bed and fell. R2 was unsure what she hit her head on, but R2 said a male staff picked her up and put her back to bed. R2 did not report fall to anyone. R2 may have been fearful. V2 said they found a towel on the floor in the bathroom with dried blood. V2 said staff must have used the towel because R2 needs assistance to get to bathroom and would not be able to get towel herself. V2 is unsure why no other staff observed the towel. V2 said staff should stay with a resident if they fall and get the nurse to assess the resident before moving the resident.

On 12/26/24 at 5:02PM, V1 (Administrator) said through his investigation it was determined V3 did

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S9999	Continued From page 3	S9999		

not follow facility protocol by not reporting a fall or change in condition to the nurse. V1 said V3's interview did not add up based on other interviews conducted and injuries observed. V1 said staff did not feel like R2 could get up unassisted and if a resident is found on the floor, staff should stay with resident and call for nurse.

R2's hospital record dated 12/11/24 at 5:30PM: Under Emergency department physician note: R2 alert and oriented x3. R2 who presents with laceration on the back of the left ear. R2 reports that she fell last night around 2AM when she was attempting to pick up a fallen tray. She slipped and fell, an event that went unnoticed by staff. R2 denied any neck or back pain but reports pain in left clavicle, shoulder, and forearm, under physical exam. Ear left with transverse laceration through the superior third auricle through the lateral edge there is exposed cartilage but its intact. Lateral edge of wound is macerated. Laceration repair: length 6 centimeter (CM), depth 8 Millimeters (MM). eleven sutures placed. Under chest x-ray documents: possible six and seven posterior rib fractures. Correlate with point of tenderness.

V3's employee file record documents: V3 terminated due to violation of code of conducts.

Facility fall policy revised 7/23 documents if a resident sustains a fall or is found on the floor without a witness to the event, associates shall evaluate for possible injuries and provide first aide treatment as indicated. A licensed nurse shall observe clinical status for 72 hours after an observed or suspected fall and document findings in clinical record.

(A)