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 _____	03/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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
S9999	Final Observations Statement of Licensure Violations (1 of 2): 300.610a) 300.1010h) 300.1210b) 300.1210c) 300.1210d)2) 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 300.1010 Medical Care Policies h) The facility shall notify the resident's physician of any accident, injury, or significant change in a resident's condition that threatens the health, safety or welfare of a resident, including, but not limited to, the presence of incipient or manifest decubitus ulcers or a weight loss or gain of five percent or more within a period of 30 days. The facility shall obtain and record the physician's plan of care for the care or treatment of such accident, injury or change in condition at the time of notification. Section 300.1210 General Requirements for Nursing and Personal Care	S9999		

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 _____	03/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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
S9999	Continued From page 1 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. 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: 2) All treatments and procedures shall be administered as ordered by the physician. These requirements were not met as evidenced by: Based on observation, interviews, and a review of records, the facility failed to follow its weight monitoring policy to prevent or reduce the risk of residents experiencing unplanned significant weight loss. This failure affected three of ten residents (R17, R28, and R61) who were reviewed for weight monitoring and weight loss as part of a sample of 40 residents. As a result, R17 experienced an unplanned weight loss of 6.15% over a 30-day period, R28 experienced a 15.3% weight loss over six months, and R61 experienced an 11.2% weight loss during a six-month period.	S9999		

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 _____	03/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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
S9999	Continued From page 2	S9999		

Findings include:

On 3/11/25 at 10:15 AM, R17 was observed to be on a pureed diet with nectar thick liquids. R17 was observed attempting to self-feed breakfast. R17 was observed to have only consumed 20% of breakfast. Staff were not observed assisting R17 with meal or encouraging R17 to eat.

On 3/12/25 12:27 PM, Staff were not observed assisting R17 with meal or encouraging R17 to eat.

On 3/12/25 at 10:45 AM, V8 RD (registered dietitian) reviewed R17's documented weights. R17 had an 8.8-pound weight loss in one month. V8 stated residents on a pureed diet should be eating in the dining room so staff can monitor them. V8 stated there is no re-weight documented. V8 stated that residents with a weight change of 5 pounds or more in one month should be re-weighed to verify the accuracy of the weight. V8 stated R17 will be re-weighed today. V8 stated V8 was not made aware of R17's weight loss.

On 3/12/25 at 11:30 AM, V8 RD stated that V8 spoke with R17 and discussed food preferences. V8 stated V8 also spoke with staff to ensure R17 is in dining room for all meals so R17 can be monitored for amount eaten.

As of 3/12/25 at 4:00 PM, R17 had not been re-weighed.

R17's medical record notes on 3/6/25, R17's weight was 134.2 pounds. On 2/5/25, R17's weight was 143 pounds. R17 had a 6.15% weight loss in one month.

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 _____	03/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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
S9999	Continued From page 3	S9999		

There is no documentation found in R17's medical record noting R17's physician was notified of R17's weight loss.

This facility's weight monitoring policy, revised 01/2023, notes residents with a weight change of five pounds or greater shall be re-weighed to determine an accurate weight. The registered dietitian should make recommendations for nutritional interventions. A nursing or nutrition associate should notify the health care provider of any significant weight change.

This facility's weighing and measuring the resident policy, revised 09/2022, notes report significant weight loss to the nurse supervisor. The threshold for significant unplanned and undesired weight loss will be based on 1 month - 5% weight loss is significant; greater than 5% is severe.
--
2) R61 was admitted to the facility on 9/10/24 with a diagnosis of muscle weakness, transient cerebral accident, dementia, hypertension, type II diabetes and heart disease. R61's weight documented on hospital transfer form dated 2/27/25 documents 59 kilograms which equals 124 pounds upon readmission.

On 3/14/25 at 11:34Am, V21 (certified nursing aide, CNA) assisted R61 in her wheelchair that measured 38.8 pounds to the wheelchair scale. Scale was balanced to zero prior to weight taken and measured at 151.2 pounds. R61 weight was 112.4 pounds.

R61's physician order dated 2/27/25 documents to weigh daily x3 days and weigh weekly x 4 weeks.

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 _____	03/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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
S9999	Continued From page 4	S9999		

Review of R61's medical record does not document any weights for R61. V19 (nursing supervisor) on 3/13/24 said there were no other weights recorded for R61 except for a written weight taken on 3/12/25 that documented 110 pounds that was just documented into the electronic record.

R61's facility weight documents weight in October: 131. Pounds and November 124.4 pounds. There were no other weights presented for R61 for this survey.

On 3/13/25 at 3;38PM, V8 (dietician) said she was made aware of R61 change in appetite on 3/5/24. There were no weights documented since November 2024. R61 had a significant weight loss of 11.2 % based on weights documented. V8 said weekly weights help to ensure weight is remaining stable, to monitor if any additional weight loss and if interventions are effective.

R61's nutrition risk assessment dated 3/12/25 documents under type of assessment: significant change. Under anthropometric data documents: height 60 inches, current weight 110 pounds, usually body weight 124 pounds, body mass index (BMI) 21.5 which indicates underweight. Under comments: Resident had significant weight loss over the past 6 months 11.2%.

R61 plan of care dated 3/4/25 documents poor PO intake with the following interventions: monitor weekly and monthly weights; monitor and record meal intakes, obtain food preferences, instruct family about dietary modifications for resident; praise resident attempts to follow diet, feed resident slowly.

Weight Monitoring Policy dated 12/2016

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 _____	03/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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
S9999	Continued From page 5	S9999		

documents: appropriate nutritional care shall be provided to resident who have a significate weight change. Each resident should be weighed daily for the first three days of admission, weekly for the first four week and monthly thereafter. Weighing and measuring the resident dated 12/2016 documents: The threshold for significant unplanned and undesired weight loss/gain will be based on the following criteria. 1 month -5% weight loss is significantly greater than 5% is severe ;3 months -7.5% weight loss is significantly greater than 7.5% is severe;6 months 10% weight loss is significantly greater than 10% is severe.
--
3) R28 was diagnosis with malignant neoplasm of endometrium. R28's care plan dated 1/11/25 documents: R28 has compromised nutritional status related to the diagnosis of sepsis, malignant neoplasm of endometrium, type one diabetes, hyperlipidemia and major depression; (2/27/25) significate weight change. Dietician note dated 2/27/25 documents: unintentional weight loss related to variable by mouth intakes as evidenced by resident with 17.3% weight loss times six months. Dietician note dated 11/29/24 documents: Unintentional weight loss related to variable by mouth intake as evidence by resident (R28) with 23 pound (lbs.) 15% weight loss in three months and 15lbs (10.3%) weight loss in one month. R28's significant weight change notification dated 11/29/24 documents: R28 had a significant weight loss of 15.3 % in three months. Plan of care: One carton of nutritional supplement once a day. Dietary recommendation/communication form dated 11/29/24 documents: reason for recommendation: significant weight loss.

On 3/12/25 at 3:41PM, R28 who was alert and

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 _____	03/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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
S9999	Continued From page 6	S9999		

orient to person, place, said she was a picky eater. R28 said, she eats very little.

On 3/13/25 at 12:36PM, R28 did not eat lunch. R28's family was at the bedside. R28's family put R28's uneaten tray on the dirty cart. R28's family said he brought food from home. V25 (CNA) said R28's family brings in food every day and feeds R28.

On 3/13/25 at 2:48pm, V25 (CNA) said R28 only likes Polish food. R28 does not drink a nutritional supplement every day.

On 3/13/25 at 4:02pm, V8 (dietitian) said, R28 had a 15.5% significant weight loss in six months.

On 3/13/25 at 5:00pm, V3 (unit manager) said R28's nutritional supplement should be signed out on the medication administration record (MAR). V3 said R28's dietitian recommendation was not on the MAR. R28's family does not come every day to feed R28.

On 3/14/25 at 10:17am, V2 (DON) said R28's recommendation for a nutritional supplement once daily was not implemented on 11/29/24 and it is not on the current MAR. V2 said the nutritional supplement should have been placed on the medication administration record. It was recommended to promote weight gain.

On 3/14/25 at 11:34am, V20 (restorative nurse) said R28's nutritional supplement was added today.

On 3/14/25 at 11:39am, V28 (nurse practitioner) said she was aware R28 was losing weight. R28 does not like the facility food. R28 has a history of malignant neoplasm of endometrium. R28 had

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 _____	03/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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
S9999	Continued From page 7	S9999		

surgery a few years ago and everything was removed. A nutritional supplement is a high calorie protein supplement that will aid in weight gain. V28 said she expected the dietitian recommendations to be implemented.

R28's weight report documents:
3/13/25 - 122.2 pounds
2/5/25 - 124.8 pounds
1/8/25 - 126.8 pounds
11/7/24- 130.0 pounds
10/9/24- 145.0 pounds

Weight Monitoring Policy dated 12/2016 documents: appropriate nutritional care shall be provided to resident who have a significate weight change.

Weighing and measuring the resident dated 12/2016 documents: The threshold for significant unplanned and undesired weight loss/gain will be based on the following criteria.
1 month -5% weight loss is significantly greater than 5% is severe.
3 months -7.5% weight loss is significantly greater than 7.5% is severe.
6 months 10% weight loss is significantly greater than 10% is severe.
(B)

Statement of Licensure Violations (2 of 2):

300.615e)

Section 300.615 Determination of Need Screening and Request for Resident Criminal History Record Information

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 _____	03/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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
S9999	Continued From page 8 e) In addition to the screening required by Section 2-201.5(a) of the Act and this Section, a facility shall, within 24 hours after admission of a resident, request a criminal history background check pursuant to the Uniform Conviction Information Act for all persons 18 or older seeking admission to the facility, unless a background check was initiated by a hospital pursuant to the Hospital Licensing Act. Background checks shall be based on the resident's name, date of birth, and other identifiers as required by the Department of State Police. (Section 2-201.5(b) of the Act) This requirement was not met as evidenced by: Based on interview and record review, the facility failed to obtain resident background check within 24 hours of admission. This failure affected 3 residents (R76, R93, R111) of 5 residents reviewed for background checks. R76, R93, and R111's resident files were reviewed and verified with V18 (Admission Director) and noted R76, R93, and R11 background checks were not completed within 24 hours of admission date. On 3-13-25 at 8:31 PM, V18 (Admission Director) said the purpose of background checks is for the safety of all residents. V18 said the background checks should be done within 24 of admission. V18 said if the name is common, this background check may take longer to clear. V18 said she could have been on vacation or away from work and the background check was not completed in time. V18 said background checks can be done before the resident is admitted.	S9999		

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 _____	03/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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
S9999	Continued From page 9 On 3-13-25 at 9:13 AM, V1 (Administrator) said background checks for residents is intended to identify resident offenders. V1 said background checks are to be done within 24 hours for resident safety. V1 said facility is working towards providing admission director back to ensure background checks are completed within 24 hours. R76's face sheet documents admission date of 1-12-25 and CHRP dated 1-17-25. R93's face sheet documents admission date of 2-8-25 and CHRP dated 2-11-25. R111's face sheet documents admission date of 2-15-25 and CHRP dated 2-18-25. (C)	S9999		