

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  145324	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  08/02/2024
NAME OF PROVIDER OR SUPPLIER  Ascension Resurrection Place		STREET ADDRESS, CITY, STATE, ZIP CODE  1001 North Greenwood Avenue Park Ridge, IL 60068	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 39781</p> <p>Based on observation, interview, and record review the facility failed to implement its fall prevention program policy by failure to implement fall prevention interventions, failure to complete fall investigation after each fall incident and failure to update care plan consistent with developed intervention based on fall investigation to prevent future falls. This deficiency affects all three residents (R1, R2 and R3) reviewed for resident safety and fall prevention program.</p> <p>Findings include:</p> <p>R1</p> <p>On 8/1/24 at 9:45AM, Observed R1 sitting in wheelchair in her room. She is alert and oriented, able to verbalize her needs. Her call light is away from her and unable to reach. She is wearing slip on shoes without socks. R1 said that she had fallen recently. She said she wheeled herself to the bathroom and when trying to grab the doorknob to stand she lost her balance and fell . She sustained fracture of her hip. She said that her call light was not within her reach and cannot call for help. She said when she fell , she yelled for help, and it took around 5 minutes for the staff to come.</p> <p>On 8/1/24 at 9:51AM, Called V7 CNA (Certified Nurse Assistant) and V8 RN (Registered Nurse) said that they are assigned to R1. Both said that R1 is at risk for fall. Both said that one of the fall prevention interventions is placing call light within reach. Showed observation made to V7 and V8 that R1's call light is away from her. Both said that it should be within reach. V8 RN positioned R1 in her wheelchair closer to bed and placed the call light within reach. V8 said that R1 should have her call light within reach for safety.</p> <p>On 8/1/24 at 11:40AM, Informed both V2 DON (Director of Nursing) and V5 Quality Improvement Nurse ([NAME]) of above observation. Both said that R1's call light should be within reach for safety.</p> <p>(continued on next page)</p>

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>R1 is admitted on [DATE] and readmitted on [DATE] with diagnosis listed in part but not limited to Orthopedic aftercare, displaced intertrochanteric fracture left femur, Repeated falls, History of falls. Fall admission assessment was done on 1/18/24 indicated that she is at high-risk for fall. MDS (minimum data set) admission assessment dated [DATE] section GG Functional abilities indicated that she needs supervision or touching assistance in sit to stand, chair to bed/bed to chair transfer and toilet transfer. She uses walker and wheelchair for mobility devices. Section C Cognitive patterns BIMS (Brief interview of mental status) obtained score of 15 indicated cognitively intact. Comprehensive care plan indicated that she is at risk for fall due to decreased strength and endurance, decreased balance, decreased mobility, unsteady gait history of Diabetes Mellitus, Hypertension, Coronary artery disease, Atrial fibrillation, Breast cancer, Hypothyroidism, fall, conjunctivitis, bilateral arm rash, status post hospitalization for repeated falls at home, weakness, bilateral neuropathy, impulsive, attempts to get up without assistance. Interventions: Keep equipment within reach- call bell, Nonskid footwear to be worn.</p> <p>R1 fall history of falls: 1) 1/26/24 at 11:10pm Unwitnessed fall, she was found lying on the floor by the bathroom door. R1 said that she was attempting to get into the wheelchair herself after using the bathroom. Fall investigation/Root cause analysis was done and formulated new fall intervention but was inconsistent with documented in updated care plan. Fall investigation new fall interventions indicated: resident needs to be reminded of the importance of call light usage at all times. Fall care plan documented for 1/26/24 -offer toilet after dinner while in IV (intravenous fluids).</p> <p>2) 3/28/24 at 6:45pm Unwitnessed fall, observed R1 sitting on the floor in front of her wheelchair beside her bed. R1 stated she was trying to transfer from her bed to her wheelchair. R1 sustained skin abrasion on left upper back (26cm x 2.5cm). Fall investigation was done and formulated fall intervention but was inconsistent with documented in updated care plan. Fall investigation intervention- Reminded resident to use call light to ask for assistance when transferring. Fall care plan documented for 3/28/24- offer toilet after dinner.</p> <p>3) 5/5/24 at 9:15pm Unwitnessed fall, R1 was seen on the floor in a sitting position in her bedroom. R1 informed the nurse that she was trying to ambulate to her bed and lost balance. R1 complained of severe leg pain. R1 was transferred to hospital for evaluation and was admitted with left femur fracture. R1 returned to the facility on [DATE]. Fall assessment done on 5/5/24 indicated that R1 is on moderate risk for fall.</p> <p>On 8/1/24 at 11:45AM, Informed both V2 DON and V5 Quality Improvement Nurse of inconsistency of fall intervention formulated from fall investigation to updated fall care plan after each fall incidents. Both said that new formulated care plan intervention from fall investigation should be consistent with fall care plan updates. Also informed both that fall assessment after 3rd fall since admission indicated moderate risk for fall. Both said that R1 should be at high risk for falls due to history of multiple falls.</p> <p>R2</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 8/1/24 at 10:00am V9 CNA said that R2 is very high risk for falls. V9 said that she is on fall prevention /fall star program. Resident identified should have star placed next to the nameplates outside the resident room. Called V9 to R2's room and showed that there is no star placed next to her name plate outside her room. V9 said that R2 is very at high risk for fall, she should have 2 stars. V9 said that the fall coordinator or manager is the one responsible for placing the star marking for residents on fall star program.</p> <p>On 8/1/24 at 10:10AM, Rounds made with V4 1st floor unit manager and V6 2nd floor unit manager to R2's room. Both said that R2 is at high risk for falls and on fall star program. V6 said that R2 should have star next to her nameplate at the door to identify as high risk for falls and on fall star prevention program. V6 said that it was not updated by fall coordinator.</p> <p>R2 readmitted on [DATE] with diagnosis listed in part but not limited to Repeated falls, Cerebral infarction. Fall re-admission assessment dated [DATE] indicated at high risk for fall. Comprehensive care plan indicated that she requires extensive assistance with ADLs (Activity of Daily Living). Fall care plan indicated that she had recent fall due to decrease safety awareness most likely attributed to her dementia, impaired standing balance and activity tolerance resulting in unsteadiness, history of multiple falls, presents with co-morbidities to include Diabetes Mellitus, Transient ischemic attack, Dementia, history of angioplasty with graft, Anemia, usage of psychotropic medication, Blood pressure medications, hypoglycemic agent, impulsive, gets up and walk abruptly without assistance. MDS (minimum date set) assessment dated [DATE] section GG Functional abilities indicated she needs supervision or touching assistance with sit to stand, chair/bed to chair transfer and toilet transfer. R2 unable to complete the BIMS interview due to cognitive impairment.</p> <p>R2 fall incidents for 2024 1) 2/11/24- Witnessed fall in the dining room. Fall assessment done after incident indicated R2 is on moderate risk for falls. Fall investigation done but no fall intervention developed. Care plan was updated on 2/11/24 remind R2 to wait for assist. 2) 3/20/24- Unwitnessed fall in her bedroom. Fall investigation done with fall intervention developed- needs to check frequently, but inconsistent with care plan updated- offer toilet around 2AM as suggested by R2's daughter. 3) 3/26/24- Witnessed fall in her room. Fall assessment done after incident indicated she is at moderate risk for fall. 4) 4/12/24- Unwitnessed fall in her room. No fall investigation completed. Care plan was updated -encourage to offer toilet after breakfast. Fall assessment after incident indicated at moderate risk for fall. 5) 4/23/24- Unwitnessed fall in the dining room. Fall assessment after incident indicated at moderate risk for fall. 6) 5/7/24- Witnessed fall in her bedroom. Fall investigation done and developed fall intervention- educated patient making sure she is safe and items within reach, but inconsistent with updated care plan- offer fluids. 7) 7/22/24- Unwitnessed fall in her room. Fall investigation done but no fall intervention developed but care plan updated. Fall assessment done after incident indicated she is at moderate risk for fall.</p> <p>On 8/1/24 at 11:30AM, Both V2 DON and V5 QA Nurse said that R2 has multiple falls since admission, just for 2024 R2 had 7 fall incidents from Feb to July 2024. Informed both V2 and V5 of inconsistency of fall intervention developed from fall investigation to updated care plan after each fall incidents. Both said that fall intervention developed from fall investigation should be consistent with fall care plan updates. Informed both that fall assessment after each fall incidents occurred indicated moderate risk for fall. Both said that R2 should be at high risk for falls due to history of multiple falls.</p> <p>R3</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 8/1/24 at 10:03AM, Rounds made to R3's room with V9 CNA. V9 said that R3 is at high risk for fall. R3 is alert and responsive with limited English language. She has oxygen via nasal cannula. R3 is lying in bed not in lowest position. V9 said that R3's bed should be in the lowest position when she is in bed. Observed the bed control is on the floor unable for R3 to reach. V9 picked up the bed control from the floor and placed R3 in the lowest position. V9 placed the bed control next to R3's pillow.</p> <p>On 8/1/24 at 10:17AM, Rounds made to R3's room with both V4 1st floor unit manager and V6 2nd floor unit manager. Both said that R3 is at high risk for fall and on fall star prevention program. Both said that R3 has care card at the back of bathroom door in her room for individualized care instructions. Observed R3 documented as at low risk for fall. V6 said R3 care card was not updated but he will update it.</p> <p>On 8/1/24 at 2:57PM, Informed both V2 DON and V5 QA RN of above concerns. Both said that R3's bed should be in the lowest position while in bed for safety and R3's care card instructions should update. Both said that R3's fall assessment after fall incident should be at high risk not at moderate risk.</p> <p>R3 is admitted on [DATE] and re admitted on [DATE] with diagnosis listed in part but not limited to Acute Congestive heart failure (CHF), Chronic obstructive pulmonary disease. Fall admission assessment dated [DATE] indicated that she is at high risk for fall. Comprehensive care plan indicated that she requires assistance with ADLs. Fall care plan indicated that she is at risk for falls due to decrease strength and endurance, decreased mobility, impaired balance, unsteady gait history of shortness of breath, dehydration, weakness, CHF. MDS assessment dated [DATE] indicated that she needs supervision or touching assistance with sit to stand, chair/bed to chair transfer, and toilet transfer. BIMS score of 3 indicated impaired cognition.</p> <p>R3's Unwitnessed fall incident in her room on 6/25/24. Observed R3 lying on floor. R3 reported that she tried to stand up to reach for her walker and she felt dizzy and fell forward onto the floor. She sustained laceration to her forehead. She was sent out to the hospital for evaluation. Fall assessment done after incident indicated that she is at moderate risk for fall. She was readmitted back to the facility on [DATE].</p> <p>Facility's policy on fall prevention revised 7/2023 indicates:</p> <p>Statement: The intent of this policy is to provide an environment that is free from accident hazards, over which there is control and provide supervision and intervention to residents to prevent avoidable accidents.</p> <p>I. Fall risk evaluation: Residents shall be evaluated by a licensed nurse during the admission process, routinely and as indicated to potential risk of fall. If the resident scores a higher risk for falls, the resident shall be placed on the Falling Star Program.</p> <p>II. Fall risk prevention. The IDT (interdisciplinary team) shall identify individualized interventions to reduce the risk for falls. If as systematic evaluation of a resident's fall risk identifies several possible interventions, the associates may choose to prioritize interventions.</p> <p>Fall ling star Program: Resident identified as members of the falling star program shall have:</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>a. A star placed next to the nameplate outside the resident room.</p> <p>b. The documentation of the identified interventions should be maintained in the resident clinical records and available to the direct care associates.</p> <p>c. If falling occurs despite initial interventions, associates shall implement additional, different interventions or indicate reason the current approach remains relevant. This documentation should be maintained in the clinical record.</p> <p>Facility's policy on Fall revised 7/2023 indicates:</p> <p>Statement overview: 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 fall.</p> <p>Policy detail:</p> <p>1. [NAME] fall risk assessment form should be utilized to complete the evaluation of the residents' potential for falls during admission process. The fall assessment should be completed quarterly, with significant MDS assessment and after very fall.</p> <p>* The documentation of the identified interventions should be maintained in the resident clinical record and available to the direct associates.</p> <p>* The fall should be reviewed at the daily stand-up meeting following the fall for identification of any additional individualized interventions to reduce the risk for falls.</p> <p>Facility's guidelines for Universal Fall prevention interventions:</p> <p>* Call light clip to enable placement</p> <p>* non-slip and well-fitting footwear encourage</p> <p>* Place bed in low position when resident is resting in bed.</p> <p>Facility's policy on Accidents and incidents investigating and reporting revised 1/2020 indicates:</p> <p>Statement: Accidents and incidents involving residents shall be investigated and reporting completed per state and federal requirements</p> <p>Interpretation and implementation:</p> <p>A. The nurse should promptly initiate and document investigation of the accident or incident</p> <p>B. The following information shall be included in the investigation as applicable:</p> <p>1. Date and time of the accident or incident took place</p> <p>(continued on next page)</p>		

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