

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 12/26/2024
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 - 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>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39340</p> <p>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.</p> <p>Findings include:</p> <p>R2 was admitted to the facility on [DATE] with a diagnosis of Covid 19, urinary tract infection, Parkinson's and overactive bladder. R2 Minimum Data Set, dated dated [DATE] documents R2 required substantial/maximal assistance (helper does more than half the effort) with sit to stand, chair to bed transfer, and toilet transfers.</p> <p>R2's fall risk assessment dated [DATE] documents: R2 is moderate risk for falls.</p> <p>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.</p> <p>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.</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 - Actual harm</p> <p>Residents Affected - Few</p>	<p>On 12/26/24 at 5:02PM, V1 (Administrator) said through his investigation it was determined V3 did 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.</p> <p>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.</p> <p>V3's employee file record documents: V3 terminated due to violation of code of conducts.</p> <p>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.</p>		