STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145324	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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. 34072 Based on observations, interviews, and record reviews, the facility failed to ensure residents were able to communicate with staff with their preferred language and failed to maintain privacy and dignity for residents with a gastrostomy tube and indwelling catheter. This affected three residents (R5, R33, and R55) reviewed for residents rights, privacy and dignity in the sample of 40 residents. Findings include: On 3/11/25 at 10:00 AM, R33 was observed with an indwelling catheter bag secured to bed frame, but not in a privacy bag. On 3/11/25 at 10:30 AM, R5 was observed with an indwelling catheter bag dangling on the left side of R5's bed without a privacy bag. On 3/11/25 at 1:05 PM, this surveyor noted R55 is Bulgarian speaking only. This surveyor communicated with R55 via an interpreter on speaker phone in the presence of V3 (nursing supervisor) and V6 SSD (social services director). R55 stated that since R55's admission to this facility, this is the first time an interpreter has been used to speak with R55. R55 stated that R55 can't get out of bed, can't walk, R55 feels like a living cadaver waiting to go to the other side. This facility's translation and/or interpretation of community services policy, revised 12/2017, notes information will be provided in a language understandable to the resident. Competent oral translation of information that is not available in written translation shall be provided in a timely manner through a telephone interpretation service or contracted interpreter service. Associates shall be educated on process to provide language access services to limited English proficiency residents. This facility's resident rights policy, revised 07/2018, notes our ministry will make every effort to assist the resident in exercising his/her rights and to assure that the resident is always treated with respect, kindness, and dignity.

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39340 Based on interview and record review, the facility failed to follow their Abuse Investigation and Reporting policy. Facility failed to submit initial report timely to IDPH (Illinois Department of Public Health) of an allegation of abuse. This deficient practice affects two residents (R51 and R327) of three residents reviewed for Abuse investigation and reporting in a total sample of 40 residents. Findings include: R51 was admitted to the facility on [DATE] with a diagnosis pneumonia, acute respiratory failure, chronic obstructive pulmonary disease and anemia. On 3/12/25 at 10:15 AM, R51 who was alert and oriented at time of interview said there was an incident on the second floor with another resident (R62). R51 said R62 hit him in his foot and knocked coffee out of his hand, spilling it on himself. R51 said he called the police and filed a report. R51's progress notes document 2/26/25: On 2/25/25 around 9:50PM, police showed up informing writer that R51 called them to report that he was assaulted by another resident on second floor around 6:30PM, his right leg was kicked and slapped his hand. No injuries observed. On 3/13/25 at 1:27PM, V2(Director of nursing, DON) said she was not aware of the incident between residents until the following day. V2 said she is not the abuse coordinator, but the incident should have been reported to Illinois department of public health (IDPH) and was not reported. On 3/14/25 at 11:56AM, V1 (Administrator) said she was unable to recall when she made aware of the allegation and referred to the nursing documentation. V1 said if a resident called the police to report assault we would report the allegation to the state. V1 said the allegation was not fully communicated to her and was not reported to the state due to V1 not being aware there was an allegation of assault. 41156 Facility reported incident for abuse allegation by R327 and with date of occurrence of 3/7/25 at 6:00AM. Facility provided fax report confirmation that Initial and Final report was submitted on 3/10/25 at 11:02AM. Facility unable to provide any other confirmation report that an initial report was sent to IDPH. On 3/12/25 at 1:15PM, V1 (Administrator) stated the initial and the final was reported the same day on March 10. V1 stated she did not report it right away because V1 was still conducting the investigation. V1 stated that V1 was busy investigating, calling the police and forgot to report the initial on that day (3/7/25). V1 stated, If it says in our policy to report abuse within 2 hours then it should have been reported within our facility policy timeframe. However, we followed our policy and investigated the allegation. Alleged staff was escorted out the facility by a nurse and reported to Agency Company for this staff to return in the facility. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Abuse Investigating and Reporting with a revised date of 11/23, reads in part: All reports of resident abuse, neglect, exploitation, misappropriation of resident property, mistreatment, electronic mail, social media, videotaping, photographing, and other imaging od residents, and/or injuries of unknown source (Abuse) shall be promptly reported to local. Stated and federal agencies (As defined by current regulation) and thoroughly investigated by the community management. Conclusions of investigation will also be reported, as defined by the ascension living Abuse Prevention policy. All alleged violations involving abuse, neglect, exploitation, or mistreatment, including injuries of an unknown source and misappropriation of property will be reported to the Administrator or designees and to the following other officials or agencies: The state licensing/certification agency responsible for surveying/licensing the community. Other officials in accordance with State Law, including to Adult Protective Services where state law provides for jurisdiction in long term care facilities. The resident's representative of record. The residents Attending Physician and the community medical director. Alleged violations involving abuse, neglect, exploitation or mistreatment (including injuries of unknown source and misappropriation of resident property) will be reported: Abuse or serious bodily harm-immediately but not later than 2 hours. If the alleges violation involved abuse or results in serious bodily injury. No serious bodily injury -as soon as practical, nut not later than 24 hours. If the alleged violation involves neglect, exploitation, mistreatment, or misappropriation of resident property; does not result in serious bodily injury. Verbal/written notices to agencies may be submitted via special carrier, fax, email, or by telephone. The Administration or his/her designee, will provide the appropriate agencies or individuals listed above with a written report of the findings of the investigation within (5) working days of the occurrence of the incident.

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F 0692 Level of Harm - Actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34072 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. Findings include: 1) 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. 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. 39340 (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Few	2) R61 was admitted to the facility on [DATE] 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. 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 [DATE] 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 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. 41758 (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Few	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 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 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 (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Few	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.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34072 41156 Based on observation, interview and record review, the facility failed to follow their Oxygen Administration and CPAP (Continuous Positive Airway Pressure) and BiPAP (Bilevel Positive Airway Pressure) support policy. The facility failed to ensure that humidifier bottle is with label and dated, failed to follow physician's order for oxygen administration and failed to obtain physician orders for the CPAP. This deficient practice affects four residents (R39, R66, R108 and R111) of four residents reviewed for respiratory care in a total sample of 40. Findings Include: On 3/11/25 at 10:00 AM, R39 was observed to have oxygen 2 liters via nasal cannula. There was no signage on R39's door noting oxygen in use. On 3/11/25 at 10:55 AM, oxygen in use signage was placed on R39's door. R39's physician order sheet reviewed and noted oxygen order at 2L/min via nasal cannula dated 2/13/25. On 3/11/25 at 10:00AM, observed R111's oxygen concentrator machine with humidifier bottle with no label and date written on it. No oxygen in use signage. CPAP machine on top of the bedside cabinet. Per R111, she's been in the facility for 3 weeks, she has been using it every night, and placed it on herself. She's been using CPAP machine at home also for [AGE] years now. Confirmed and verified with V3 (Nurse) that there is no date and signage, and CPAP machine is on the bedside cabinet at 10:25AM. R111's physician order sheet reviewed and noted an order for oxygen at 2L/min per NC (Nasal Cannula) dated 2/16/25. No orders for CPAP machine set up and flow. On 3/11/25 at 10:20AM, observed R66's room. R66 in bed with oxygen on at the rate of 4L oxygen via nasal cannula. Humidifier not dated. Confirmed and verified with V3 that there is no label and date in the humidifier bottle, and that R66 is receiving 4L/min per NC at t 10:28AM. V3 also confirmed the order for R66's oxygen order as 2-3L/min continuous. R66's physician order sheet reviewed and noted an order for oxygen at 2-3L/min via NC dated 2/28/24. On 3/11/25 at 11:15AM observed R108 in bed, and on 3L/min oxygen via NC. Humidifier not dated and at 11:22AM confirmed and verified with V3 that there is no label and date in the humidifier bottle and R108 is on oxygen via NC. R108's physician order sheet reviewed and noted that there is no order for oxygen administration for R108. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 3/13/25 at 10:45AM. V2 (DON) stated that oxygen in use signage need to be displayed by the resident's door if a resident is on oxygen and even PRN (as needed) oxygen orders needs to signage by the door because they can use oxygen at any time. Humidifier needs to be dated, so we know when to change it. We need to have physician's order for oxygen administration and to follow the order; And CPAP machine with setting. CPAP/BIPAP support policy with a revised date of 9/2019, reads in part: To provide spontaneous breathing resident with continuous positive airway pressure with or without supplemental oxygen. To improve arterial oxygenation (Pa02) in residents with respiratory insufficiency obstructive sleep apnea or restrictive/obstructive lung disease. To promote resident comfort and safety. Under preparation: A qualified and properly trained nurse or respiratory therapist should administered oxygen through a CPAP mask Review the physician's order to determine the oxygen concentration and flow, and the PEEP pressure (CPAP, IPAP and EPAP) for the machine. Under Procedure: Set mode, CPAP, IPAP and EPAP settings on the machine as prescribed. Oxygen Administration policy with a revised date of 10/2018, reads in part: The purpose of this procedure is to provide guidelines for safe oxygen administration. Verify that there is a physician's order for this procedure. Review the physician's orders or community protocol for oxygen administration. No Smoking/Oxygen in Use signs, as required by state and federal requirements. Place an Oxygen in Use sign on the outside of the room entrance door, per state and federal requirements. Label and date the humidifier bottle and oxygen tubing.

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. 34072 Based on observations, interviews, and record reviews, the facility failed to accurately assess one resident's (R55) pain, implement interventions, and monitor for the effectiveness of the interventions out of 3 residents reviewed for pain management in a sample of 29. Findings include: On 3/11/25 at 1:05 PM, this surveyor noted R55 is Bulgarian speaking only. This surveyor communicated with R55 via an interpreter on speaker phone in the presence of V3 (nursing supervisor) and V6 SSD (social services director). R55 stated that R55 receives medications but does not know what they are for. R55 stated nearly every day R55 has a headache in the morning. R55 stated today R55 has a migraine. R55 stated when R55 has a headache at night, R55 has difficulty sleeping and tosses and turns all night. R55 stated R55 points to head when in pain. R55 stated R55 does not know if the nurse is administering any pain medication to R55. R55 stated since R55's admission to this facility, this is the first time that an interpreter has been used to speak with R55. R55 stated R55 can't get out of bed, can't walk, R55 feels like a living cadaver waiting to go to the other side. On 3/11/25 at 1:15 PM, V3 (nursing supervisor) stated V3 will inform R55's nurse of R55's migraine. This facility's medication administration policy, revised 01/2025, notes in part, the facility staff will review the current/active medication list with the resident.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. 34072 Based on observations, interviews, and record reviews, the facility failed to follow its infection control policy for enhanced barrier precautions and don the appropriate PPE (personal protective equipment) prior to providing direct resident care. This failure affected two residents (R33 and R39) out of three residents reviewed for infection control in a sample of 40. Findings include: On 3/11/25 at 10:00 AM, during initial tour, enhanced barrier precaution signage was observed at R33 and R39's rooms. On 3/11/25 at 11:05 AM, V10 (Registered Nurse) was observed providing gastrostomy tube care for R33. V10 was not wearing appropriate PPE (personal protective equipment); V10 did not don a gown. On 3/11/25 11:30 AM, V11 CNA (Certified Nurse Aide) was observed removing a package of wipes from another resident's room and bringing into this R39's room to provide incontinence care. V10 assisted R39 with dressing and transferring R39 to wheelchair. V11 was observed not donning appropriate PPE prior to entering R39's room; V11 did not don a gown. On 3/12/25 at 2:00 PM, V15 IP Nurse (Infection Prevention Nurse) stated enhanced barrier precautions are implemented for residents with wounds, gastrostomy tubes, devices, and indwelling catheters. V15 stated staff are expected to wear gown and gloves when providing direct patient care for residents on enhanced barrier precautions. On 3/12/25 at 3:00 PM, V10 RN (Registered Nurse) stated if the resident is on enhanced barrier precautions, the staff need to don gloves prior to providing care. V10 stated if the staff member thinks there will be spillage, then he/she should wear a gown also. The enhanced barrier precautions signage posted outside R33 and R39's rooms notes all healthcare personnel must wear gloves and gown for the following high-contact resident care activities: dressing, bathing/showering, transferring, providing hygiene, changing briefs or assisting with toileting, device care or use (intravenous line, urinary catheter, ostomy, feeding tube (gastrostomy), and tracheostomy), and wound care.