STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145960	A. Building B. Wing	03/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ascension Resurrection Life	7370 West Talcott Avenue Chicago, IL 60631

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)
F 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49572 Based on interview and record review, the facility failed to provide adequate supervision and failed to follow the Care Plan implementing fall prevention interventions to one resident (R1) reviewed for resident injury. This failure resulted in R1 falling and sustaining bilateral subdural hemorrhages and a right parietal subarachnoid hemorrhage. R1 was admitted to the intensive care unit. Findings include: R1's hospital records, dated 2/14/2025, documents, in part, . presents to ED (emergency department) with chief complaint of Fall . Patient (R1) sustained hematoma to left orbit and skin tear to left elbow . CT (computed tomography) Cervical Spine WO (without) contrast, CT head WO Contrast, 2/14/2025 10:56 PM. Findings: Head: Small acute bilateral cerebral convexity subdural hematomas measuring 5 mm on the left and 3 mm on the right without significant mass effect. There is adjacent small right parietal subarachnoid hemorrhage measuring 7 mm. There is mild hyperdense thickening along the right tentorium compatible with small subdural hemorrhage . Drowsiness responding very minimally with pain stimulus. Patient admitted for subdural hematoma secondary to trauma more of conservative management at this time . Patient (R1) is a 92 y.o. (year old) male who presents to the ICU (intensive care unit) for bilateral subdural hematomas and small right subarachnoid hemorrhage . R1's progress note, dated 2/15/25 at 7:49 am, documents, in part, Called ER (emergency room) at (hospital) ., resident admitted with DX (diagnosis): subdural hematoma, kitchen, pharmacy and housekeeping notified. R1's Fall Risk Assessment, dated 2/12/2025 at 10:10 am, documents, in part, a total score of 25 which indicated R1 is at a moderate risk for falls. R1's Care Plan, start date 11/19/24, documents, in part, (R1) is at risk for falls related to change in environment. (R1) wants to remain free from injury related to falls over the next review period . Keep bed at the appropriate height . R1's Care Plan, admitted date 2/20/25, documents, in part, (R1) needs assistance with daily ADL (activities of daily living) care . Bed Mobility: (R1) need extensive assistance with 2 person staff support. I (R1) use 2 side bed assistive device(s) . Toileting: I (R1) need total assistance with 2 person staff support. (continued on next page)

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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F 0689 Level of Harm - Actual harm Residents Affected - Few	R1's Face Sheet documents medical diagnoses that include but are not limited to dementia, osteoarthritis, bilateral hearing loss, stiffness of right knee, stiffness of left knee, unsteadiness on feet, lack of coordination, need for assistance with personal care, muscle weakness, and difficulty in walking. R1's Minimum Data Set (MDS), dated [DATE], documents, in part, a Brief Interview of Mental Status (BIMS) score of 01 which indicates that R1's cognition is severely impaired. R1 is unable to be interviewed due to R1's mental status. On 3/17/2025 at 12:33pm, V6 (R1's Family Member) said, I (V6) was notified of (R1's) fall on February 14th (2/14/25) by the facility. The CNA (V8 Certified Nursing Assistant) had the bed all the way up because she's (V8) tall. She (V8) went to the sink to go get a rag and that's when he (R1) fell . She (V8) shouldn't have left the bed up like that and shouldn't have left him (R1) at the edge of the bed. They (facility) called me at like 10:30 pm. I (V6) told them (facility) that I (V6) don't ever want her (V8) to touch him (R1) again. He (R1) has Alzheimer's. They (staff) should know better. Can you believe they (facility) didn't fire her (V8)? They (facility) just moved her (V8) to a different floor. He (R1) has been at this facility for 4 years. I (V6) have visited him (R1) every day since he's (R1) been here. Just recently I (V6) don't visit him on Saturdays because my family made me. On 3/17/25 at 1:40pm, V7 (Nurse Practitioner) said, Yes, I know (R1). I've been taking care of him (R1) since se he got here. Like for 3 to 4 years. I've been here 8 years. All I know is he fell off the bed. I didn't directly assess (R1). He came back with the bleed, non-operable. (R1's) dementia was advancing and he was having trouble swallowing. No, I just heard he was getting changed and fell somehow. I'm a subcontractor. Not directly employed by facility. When asked if the fall caused harm to R1, V7 replied, It didn't help him. In a way yeah. On 3/17/25 at 2:18pm, V8 (CNA) said, Yes, I was the CNA for him (R1) when he fell out of bed. It was around 9:50 pm on Valentine's Day. I was doing my last check and change. I put him on the potty, and he took a poo. I needed more material, so I went to the sink to get towels. When I turned around, I seen him falling and tried to catch him. He rolled over on me. The bed was still up to about my hip. I did not let it (R1's bed) back down. Normally everything be cool. Yes, I should have all supplies available when I do care. On 3/18/25 at 10:58 am, V3 (Interim Director of Nursing/DON) said, I know him (R1) a little bit. I am familiar with the incident itself (Fall that occurred on 2/14/25). I was notified of incident, (R1) sent out, report came in as a result of fall and an intracranial bleed. When interviewing the CNA (V8) it was a witnessed fall. (V8) went into room to provide care, stated (R1) had an unexpected bowel movement and she went to get additional supplies. In her words, (R1) was in bed, laying on right side, (V8) went to the sink and observed (R1) leaning further over. She (V8) tried to reach (R1) but was unsuccessful and (R1) fell from the bed to the floor. (R1) was assessed by the nurse and sent out. Residents on LAL (low air loss mattress) should have 2 person assist. Based off that, I began educating staff when residents are on a low air loss mattress, they (residents) should be a 2 person assist because when you're (residents) on air mattresses they (air mattresses) are constantly shifting. Moving forward LALs should be a 2 person assist for safety. She knew stepping away from the bedside was not a good call. As a one person assist, she should have repositioned him on his back, centered, and lowered the bed. Don't step away from the bed until lowered and positioned in bed. All those safety checks should have been done. If she would have done the safety checks the fall would likely not have happened. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	On 3/18/25 at 11:32am, V1 (Administrator/Executive Director) said, I am familiar with (R1). I (V1) am familiar with the incident of him falling out of the bed (fall incident on 2/14/25). When asked if R1's fall incident on 2/14/25 was it preventable, V1 replied, Possibly but I'm (V1) not a nurse. When asked if R1's fall incident on 2/14/25 caused harm to R1, V1 replied, I (V1) don't feel it changed his condition. He (R1) has been declining. I'm (V1) not a nurse to assess and clinically cannot make that statement. R1's FRI (facility reported incident), dated, 2/14/25, documents, in part, On 2/14/25 at approximately 9:50pm (R1) was receiving incontinence care from a CNA (certified nursing assistant, V8). The CNA rolled him on his right side and then stepped away to grab more wipes and soap to clean him. The CNA turned back towards and noticed he was leaning towards the edge of the bed. She quickly tried to get to the bed but (R1) rolled off the bed hitting his head on the floor . A bump on the right side of his forehead was found . 911 was called . He was transferred to the hospital . The RN (registered nurse) followed up with the hospital and he was admitted with subdural hematoma. Facility policy titled, Safety and Supervision of Residents, revised date 12/2017, documents, in part, . C. Residents should be visualized for safety during routine rounds and per care plan for individual needs . Facility presented document titled, Procedure: Assisting the Nurse in Examining and Assessing the Resident, revised date 12/2017, documents, in part, The purpose of this procedure is to assist the nurse in gathering information about the overall condition of the resident and his/her performance of activities of daily living (ADL). With a goal that the resident's abilities in activities of daily living do not diminish unless circumstances of the individual's clinical condition demonstrate that a decline was unavoidable. A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming and personal hygiene . A. Activities of daily living (AOL) include the resident's physical, psychological, social, and spiritual activities. B. During daily contact with the resident, observe the resident's level of independence in performing ADL. While observing the resident, note if the resident performs activities of daily living: 1. Without assistance; 2. With some assistance; or 3. With total assistance; . E. Toileting -when assisting with personal toileting needs, note: 1. Assistance needed with going to the bathroom; . Facility policy titled, Fall Policy, revised date 7/2023, documents, in part, . 1. Fall Risk Assessment form (or similar fall risk evaluation) should be utilized to complete the evaluation of the residents' potential for falls during the admission process . Fall Risk Assessment form (or similar fall risk evaluation) should be completed quarterly, with significant change MDS Minimum Data Set) Assessment and after every fall .