STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146180	A. Building B. Wing	12/31/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ascension Nazarethville Place	300 North River Road Des Plaines, IL 60016

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 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to implement its policies and procedures to prohibit and prevent abuse. This deficiency affects (R1) of three residents reviewed for Abuse Prevention Program. Findings include:On 12/31/25 at 9:12AM, V3 Family member/R1's sister said that she was notified by nurse that R1 had bruised on right hand and forearm last week. R1 had incidents of found bruises in the facility. V3 said that they are not doing anything to prevent her from having these bruises. V3 believed that R1 is being abused.On 12/31/25 at 9:27AM, V1 Administrator said that last week 12/24/25, R1 was observed to have bruises on her hand. V1 said he already submitted facility reported incident to IDPH. V1 said that R1 had incident reported last [DATE] due to unknown bruising on her left eyebrow. V3 Family member/R1's sister who is also a resident in the facility in another unit, who keeps on calling the IDPH for abuse allegations. V3 is accusing facility of abusing R1 due to her occurrences of bruises. He said that R1 has behavioral issues of agitation and physical aggression. She has tendency to resist care and swing her arms that may hit hard objects. R1 is on blood thinning medication which bruising is expected side effects.On 12/31/25 at 9:33AM, Observed R1 up in high back chair in the 2nd floor hallway near the nursing station. She is alert to herself and responsive but irritated and does not want to be bothered.On 12/31/25 at 9:35AM, V4 LPN (Licensed Practical Nurse) said that she is regular nurse assigned for R1. R1 is alert but confused and has behavioral issues of agitation and resistive to care. R1 had history of bruises due to her medication side effects and agitations. She has tendency to swing her arms when resisting care and may hit hard objects. Surveyor asked V4 to check bruises on right hand and forearm. Observed fading bruises yellow green discoloration on right dorsal hand and forearm. R1 said she did know what had happened to her hand and does not want to be bothered.On 12/31/25 at 10:17AM, Both V1 Administrator and V2 Social Service Director (SSD) said that V3 Family member called multiple time to IDPH for allegations of resident abuse to R1. All allegations are unsubstantiated. Both said that abuse /neglect assessment are done upon admission, quarterly, annually, significant change and in allegation of abuse.On 12/31/25 at 10:30AM, Reviewed R1's medical records with V1 Administrator. R1 is re- admitted on [DATE] with diagnosis listed in part but not limited to Parkinson's disease, Atrial fibrillation, Congestive heart failure, Hypertension, Type 2 Diabetes Mellitus, Stage 3 chronic kidney disease, Dementia, Anxiety disorder, Depression, Cognitive communication deficit, Psychosis, History of falling. Active physician order sheet indicated: Alprazolam 0.25mg tablet by mouth every 8 hours as needed for anxiety. Eliquis 2.5mg tablet by mouth twice a day for atrial fibrillation. Escitalopram 5mg tablet by mouth every day for Depression. Donepezil 10mg tablet by mouth every day for Alzheimer's disease. R1's facility incident report of abuse allegation dated 10/10/25 and 12/24/25. Active comprehensive care plan indicated: Cognitive loss/dementia. She demonstrates altered level of cognitive function due to unspecified dementia, depression, anxiety disorder and unknown psychosis as evidenced by intermittent episodes of verbal and physical aggression particularly during care interactions with CNA (Certified Nurse Assistant)s. Intervention: Monitor behaviors to ensure staff and resident safety while exploring appropriate interventions. She needs assistance with daily ADL (Activity of daily livings) care, impaired functional mobility/wheelchair bound, resistive to care, 2 staff will be present to provide ADLs at all times. She is at risk for abuse and neglect. She is cognitively impaired. Diagnosis of dementia, psychosis, depression, and anxiety. Prefers to be in her room, social isolation. Reported for resistive to care verbally and behavioral aggression. Abuse care plan was not updated after allegation of abuse on 12/24/25. No abuse/neglect assessment was found for 2025. No abuse assessment was done after abuse allegation incident in October and December 2025.On 12/31/25 at 10:56AM, V6 RN (Registered Nurse) said that she is the regular nurse and the assigned nurse on the day of incident (12/24/25 3-11 shift) . Around 4pm, V7 CNA reported of observing bruise on R1's right wrist and forearm. V6 RN assessed R1's right wrist bruise measuring 4cm x 3cm and right forearm bruise measuring 2cm x 2cm. R1 denied pain upon assessment. V6 notified primary care physician and ordered x-ray of right hand. She notified V3 Family member, who is a resident in another unit and visited R1. Around 9pm, V3 informed V6 that she called police officer because she believed that the bruises are from abusing R1. Around 10pm, the police officer came and conducted investigation. V6 updated V1 and V2 of the incident. V6 said that R1 is prone to bruising due to anticoagulant medication side effects and her behavioral issues of agitations. She may swing her arms when agitated and may hit hard objects. V6 said that they used to apply Geri sleeves to protect her upper arms, but she refused. V6 did not remember if she documented it

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review facility failed to ensure to provide adequate supervision and develop new care plan intervention to prevent injury/bruising to resident who has history of injury of bruising. This deficiency affects one (R1) of three residents reviewed for Adequate supervision and Prevention of Injury.Findings include:On 12/31/25 at 9:12AM, V3 Family member said that she was notified by nurse that R1 had bruised on right hand and forearm last week. R1 had incidents of found bruises in the facility. V3 said that they are not doing anything to prevent her from having these bruises. V3 believed that R1 is being abused.On 12/31/25 at 9:27AM, V1 Administrator said that last week 12/24/25, R1 was observed to have bruises on her hand. V1 said he already submitted facility reported incident to IDPH. V1 said that R1 had incident reported last [DATE] due to unknown bruising on her left eyebrow. V3 Family member/R1's sister who is also a resident in the facility in another unit, who keeps on calling the IDPH for abuse allegations. V3 is accusing facility of abusing R1 due to her occurrences of bruises. He said that R1 has behavioral issues of agitation and physical aggression. She has tendency to resist care and swing her arms that may hit hard objects. R1 is on blood thinning medication which bruising is expected side effects.On 12/31/25 at 9:33AM, Observed R1 up in high back chair in the 2nd floor hallway near the nursing station. She is alert to herself and responsive but irritated and does not want to be bothered.On 12/31/25 at 9:35AM, V4 LPN (Licensed Practical Nurse) said that she is the assigned nurse for R1. She said, that R1 is alert but confused and has behavioral issues of agitation and resistive to care. R1 had history of bruises due to her medication side effects and agitations. She has tendency to swing her arms when resisting care and may hit hard objects. V4 said that R1 needs assistance with ADLs (Activity of daily living) and transfers. She needs 2-person mechanical lift transfer. V4 said that R1 has bilateral floor mats. V4 said that they are not using Geri sleeves (Protective sleeves), or side rails pad for R1. for Surveyor asked V4 to check bruises on right hand and forearm. Observed fading bruises yellow green discoloration on right dorsal hand and forearm. R1 said she did know what had happened to her hand and does not want to be bothered. Observed R1's room with V4 LPN. Observed bilateral floor mats against the wall. 2 pillows on the bed.On 12/31/25 at 9:44 AM, V5 CNA (Certified Nurse Assistant) said that she is the assigned CNA for R1. R1 is alert but confused and has behavioral issues of agitation and resistive to care. She is aware that R1 has bruised on her right hand. R1 has tendency to swing her arms when resisting care and may hit hard objects. V4 said that R1 needs assistance with ADLs and transfers. She needs 2-person mechanical lift transfer. V4 said that R1 has bilateral floor mats. V4 said that they are not using Geri sleeves, or side rails pad for R1.On 12/31/25 at 10:17AM, Both V1 Administrator and V2 Social Service Director (SSD) said that V3 Family member called multiple times to IDPH for allegations of resident abuse to R1. All allegations are unsubstantiated. Both said that abuse /neglect assessment are done upon admission, quarterly, annual, significant change or in allegation of abuse.On 12/32/25 at 10:30AM, Review R1 medical records with V1 Administrator. R1 is re-admitted on [DATE] with diagnosis listed in part but not limited to Parkinson's disease, Atrial fibrillation, Congestive heart failure, Hypertension, Type 2 Diabetes Mellitus, Stage 3 chronic kidney disease, Dementia, Anxiety disorder, Depression, Cognitive communication deficit, Psychosis, History of falling. Active physician order sheet indicated: Alprazolam 0.25mg tablet by mouth every 8 hours as needed for anxiety. Eliquis 2. 5mg tablet by mouth twice a day for atrial fibrillation. Escitalopram 5mg tablet by mouth every day for Depression. Donepezil 10mg tablet by mouth every day for Alzheimer's disease. Active comprehensive care plan indicated: Cognitive loss/dementia. She demonstrates altered level of cognitive function due to unspecified dementia, depression, anxiety disorder and unknown psychosis as evidenced by intermittent episodes of verbal and physical aggression particularly during care interactions with CNAs. Intervention: Monitor behaviors to ensure staff and resident safety while exploring appropriate interventions. She needs assistance with daily ADL care, impaired functional mobility/wheelchair bound, resistive to care, 2 staff will be present to provide ADLs at all times. She is at risk for pressure ulcer and other skin related injuries. 10/11/25 left eye redness and closed linear lesion of left forehead/healed. CT of head and cervical spine done. Intervention: Observe skin for redness and breakdown during routine care. She is at risk for complications from blood thinning medication. Eliquis as ordered. Monitor for presence of absence of signs of active bleeding such as hematuria, petechiae, bruising, bloody stool or nosebleed at least daily. Total body checks for all anticoagulants except for ASA are done with baths by CNAs and once a week by licensed nurse. This