PRINTED: 01/31/2021 FORM APPROVED Illinois Department of Public Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: _____ B. WING IL6006506 11/25/2020 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **300 NORTH RIVER ROAD ASCENSION NAZARETHVILLE PLACE** DES PLAINES, IL 60016 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PRÉFIX **PREFIX** REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE DATE TAG TAG DEFICIENCY) S 000 Initial Comments S 000 Facility Reported Incident of 6/15/20/IL125994 -F689 G cited S9999 S9999 Final Observations Statement of Licensure Violations: 300.1210b)5) 300.1210c) 300.1210d)6) 300.3240a) Section 300.1210 General Requirements for Nursing and Personal Care The facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive resident care plan. Adequate and properly supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident. Restorative measures shall include, at a minimum, the following procedures: All nursing personnel shall assist and 5) encourage residents with ambulation and safe transfer activities as often as necessary in an effort to help them retain or maintain their highest

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Pursuant to subsection (a), general

Each direct care-giving staff shall review and be knowledgeable about his or her residents'

practicable level of functioning.

respective resident care plan.

TITLE

Attachment A

Statement of Licensure Violations

(X6) DATE

Illinois Department of Public Health (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING; ___ B. WING IL6006506 11/25/2020 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **300 NORTH RIVER ROAD ASCENSION NAZARETHVILLE PLACE** DES PLAINES, IL 60016 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (X5) (EACH DEFICIENCY MUST BE PRECEDED BY FULL PRÉFIX **PREFIX** (EACH CORRECTIVE ACTION SHOULD BE COMPLETE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY) S9999 Continued From page 1 S9999 nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour, seven-day-a-week basis: All necessary precautions shall be taken 6) to assure that the residents' environment remains as free of accident hazards as possible. All nursing personnel shall evaluate residents to see that each resident receives adequate supervision and assistance to prevent accidents. Section 300.3240 Abuse and Neglect a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. (Section 2-107 of the Act) These Regulations were not met as evidenced bv: Based on observation, interview, and record review, the facility failed to use a mechanical lift with two staff members while transferring a resident from bed to wheelchair and back. This failure affected one (R1) resident reviewed for transfers and resulted in R1 sustaining a left femur (thigh bone) fracture requiring hospitalization and surgical intervention. Findings include: R1 is an alert and oriented 95 year old resident with diagnosis of hypertension, anemia and history of transcient ischemic attack and cerebral infarction. A facility fall risk assessment dated 6/2/20 shows R1 with a total score of 5 signifying that she is at high risk for falls.

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A facility incident report dated 6/15/20 written by V2 (Director of Nurses) at 12:40 PM states, "On

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Illinois Department of Public Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: _ C B. WING IL6006506 11/25/2020 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 300 NORTH RIVER ROAD **ASCENSION NAZARETHVILLE PLACE DES PLAINES, IL 60016** SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID ID (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PRÉFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS REFERENCED TO THE APPROPRIATE DATE TAG TAG DEFICIENCY) S9999 Continued From page 2 S9999 6/15/20 at 8:30 am, resident (R1) was being transferred by (V5) assigned CNA (certified nurses aide) from bed to wheelchair, resident complained of left leg weakness, and CNA eased her down on the floor, and called out for assistance. Assessment done, no physical injury noted, resident complained of left knee pain 2/10: ibuprofen given. Resident was transferred to bed via hover (mechanical) lift with 2 assist, MD informed, order received to do X-ray left hip and left knee. 6/15/20 at 12:24 PM, X-ray result shows acute fracture left distal femur. MD informed and order received to send resident to hospital for evaluation. 9:24 PM Nurse on duty called hospital ER and was informed resident's admitting diagnosis is closed fracture left distal femur. Investigation: Based on resident's medical record, staff's and resident interview, on 6/15/20 at approximately 8:30 AM, assigned CNA was transferring resident from bed to wheelchair. resident complained of left leg weakness. resident was eased to the room floor and CNA called out for assistance. Resident is alert and oriented x 4. When asked what happened, she stated, "I think the screws in my knees are getting weak, I told the aid, and she sat me down slowly on the floor, I did not hit my head". Medical records recieved form the hospital shows resident has prosthesis in her left femur and she sustained Supracondylar periprosthetic fracture left distal femur." Interview with V3 (LPN) on 11/16/20 at 11:14 AM stated, "I was working on the floor doing a medication pass around 8:30/9:00 AM when the CNA (V5) came over and called me and says that (R1) is on the floor so I went to her room and saw her sitting upright on the floor leaning against the

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dresser drawer. I did the assessment and I checked her body and legs for any injury. I asked

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Illinois Department of Public Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: _ C B. WING IL6006506 11/25/2020 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **300 NORTH RIVER ROAD ASCENSION NAZARETHVILLE PLACE** DES PLAINES, IL 60016 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** (EACH CORRECTIVE ACTION SHOULD BE DATE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) S9999 Continued From page 3 S9999 the resident if she was in pain and she denied any pain. She (R1) said to me "I fell." I asked her if she hit her head and she said she did not." Surveyor asked how many staff was required to lift and transfer (R1), V3 stated, She is a hover (mechanical) lift times 2 person assist...Normally 2 staff are required to safely transfer someone (using a lift). Asked what V5 told her as to how R1 fell, V3 stated, She said that during the transfer (R1) lost her balance and so V5 eased her down to the floor but she (V5) admitted she did not get help which she should have for R1. Asked what R1's current level of transfer assistance is needed, V3 stated, She requires extensive assist times 2 persons and we use the hoyer (mechanical) lift to transfer her. 11/16/20 at 11:35 AM, R1 stated, There was this young girl who got me up or at least she tried to get me up. She said, I'm going to get you dressed now. I said to her, Okay and I didn't think much of it when she was going to try to get me up to get dressed but I was concerned because she was by herself so I asked her if she could get someone to help her. She said that she could do it fine herself and she was in a bit of a hurry, but I let her do it anyway because she insisted. I told her again before she started that I was just dead weight and that she needs to get some help, but she just went about what she was going to do and ignored my requests. Surveyor asked if she recalled V5 using a belt or any mechanical device to try to assist in transferring her. R1 stated, Oh no, she just took her arms and put them under mine and tried to lift me up. There was no belt that she used on me. When she got me up and tried to maneuver me over to the bed was when I knew I was going down, because like I said I'm dead weight, and I just dropped down and fell to

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the ground. My feet fell under the bed and I hit my

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I didn't use it. Surveyor asked if she was

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		IL6006506	B. WING	· · · · · · · · · · · · · · · · · · ·	11/2	5/2020
NAME OF F	PROVIDER OR SUPPLIER	STREET ADD	DRESS, CITY, S	TATE, ZIP CODE		
ASCENS	ION NAZARETHVILLE	E PLACE 300 NORT	H RIVER RO	AD		
ASCENS	ION NAZANE III VIELI	DES PLAI	NES, IL 600	16		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
S9999	Continued From page 5		S9999			3 0 0 0 0 0 0 0 0 0
	educated on the type needed to safely trawas told she needed and there was a she this." Asked if anyor plan of care related just the sheet in the she did not look at the sheet in the sheet in the sheet in the sheet in the sheet or look at the sheet or card pertaid don't know what the called surveyor back volunteered to dem with R1. V7 stated the was in R1's closet. R1's name and rook Hoyer (mechanical device needed to sathe demonstration around R1's waist, to lift and transfer R don't need it, I use it told me to use it." Reither on me, I don't now." Surveyor ask lift was to transfer R doesn't use thatthe the second floor buthere.	pe of transfer requirements R1 ansfer and V5 stated, "I know I d only one person to transfer eet in her drawer that says ne discussed with her R1's to transfers, V5 stated, Well e drawer and also stated that the sheet in question. M, surveyor entered R1's above mentioned sheet that er and asked V7 (CNA) who aroom geting R1 ready. Out a sheet of paper with R1's 5 stated, "I don't know of any 1's ever referred to any type of ining to R1's care, V7 stated, "I at is." At 10:30 AM, V7 (CNA)				
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

IL6006506

NAME OF PROVIDER OR SUPPLIER

ASCENSION NAZARETHVILLE PLACE

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:

(X2) MULTIPLE CONSTRUCTION
A. BUILDING:

C
B. WING

STREET ADDRESS, CITY, STATE, ZIP CODE

300 NORTH RIVER ROAD
DES PLAINES, IL 60016

(X4) ID. PROVIDERS PLAN OF CORRECTION (X5)

NAME OF F			TATE, ZIP CODE					
ASCENSION NAZARETHVILLE PLACE 300 NORTH RIVER ROAD DES PLAINES, IL 60016								
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE				
S9999	person assist but now she needs two people and a mechanical lift transfer. Asked how many people are required to safely use a mechanical lift and V2 stated, "One person." Asked again if one person can safely place a resident on a sling then lift them with the mechanical lift, V2 stated, She needs two people. 11/17/20 at 11:30 AM, V9 (Minimum Data Set and Care Plan Coordinator) stated, I create the MDS (Minimum Data Set assessment) and do the care plan with the help of the interdisciplinary team. (R1) needs extensive assist in transfers and she is coded as a "3" which means a two person	S9999						
	assist. 11/25/20 at 10:30 AM, V9 stated, In order to safely transfer any resident using the mechanical lift, you will need two people. You need two because you still have to place the resident on the sling, secure the sling on to the mechanical lift and one staff to run the control device. It's not safe for just one person to use.							
	MDS dated 6/25/20 documents that R1 is totally dependent on staff for transfers from bed to wheelchair and with 2 or more persons physical assistance as support in performing this task. The most current MDS dated 9/18/20 shows R1 requiring extensive assistance with staff providing weight-bearing support but still requiring 2 or more persons physical assistance as support in performing the task.							
	Care plan for R1 dated 10/29/2019 (prior to fall with sustained fracture) includes: (R1) is at risk for falls related to impaired balance during transfers, limited physical mobility secondary to chairbound status; medication side effects and use of mobility device. Goal: (R1) will not have fall							

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FORM APPROVED Illinois Department of Public Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: _ B. WING_ IL6006506 11/25/2020 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **300 NORTH RIVER ROAD ASCENSION NAZARETHVILLE PLACE** DES PLAINES, IL 60016 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION ID (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PRÉFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) DATE TAG **DEFICIENCY**) S9999 Continued From page 7 S9999 related injuries through the next review date. Approaches: Ensure that wheelchair brakes are locked prior to transferring; prefers wearing tennis shoes, needs a night light on to help see at night, monitor for changes in condition that may warrant increased supervision/assistance." There were no specific interventions pertaining to safe transfer. (A)

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