STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6007892	A. BUILDING: _____ B. WING _____	C 05/04/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASCENSION RESURRECTION PLACE	1001 NORTH GREENWOOD AVENUE PARK RIDGE, IL 60068

(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
S 000	Initial Comments Complaint Investigation #2192651/IL132956	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.1210b) 300.3240b) 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. Section 300.3240 Abuse and Neglect A facility employee or agent who becomes aware of abuse or neglect of a resident shall immediately report the matter to the facility administrator. (Section 3-610 of the Act) There Regulations are not met as evidenced by: Based on interview and record the review the facility failed to prevent a resident to resident assault for 1 of 4 residents (R1) reviewed for abuse. The failure resulted in R2 attacking and pushing R1 to the floor R1 was sent to the local hospital and assessed and treated for a Non displaced fracture of the greater trochanter.	S9999	**Attachment A** Statement of Licensure Violations	

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S9999	Continued From page 1	S9999		

Findings include:

R1's diagnoses (per face sheet) include but not limited to Parkinson's Disease, Type II Diabetes Mellitus and History of Falling. R1's BIMS (Brief Interview for Mental Status) dated 1/12/21 was 4 indicating severe cognitive impairment.

On 5/3/21 at 11:18am, R1 was interviewed (through a phone patch Spanish speaking interpreter) but unable to get pertinent answer regarding 1/1/21 incident. R1 was observed using a rolling walker to ambulate.

R2's diagnoses (per face sheet) include but not limited to Parkinson's disease, Vascular Dementia, and Major depressive Disorder. On 5/3/21 at 10:56am R2 was interviewed but unable to get pertinent answer about what happened on 1/1/21. R2's BIMS, dated 12/23/20 was 14- intact cognition.

On 5/3/2021 at 1:38pm, V3 (Registered Nurse) said that on 1/1/21, after escorting (R1) to his room, and going back to the nursing station, she heard a sound coming from (R1) and R2's room. When V3 went to the room, she found R1 on the floor and R2 was sitting on his wheel chair. R2 said that he pushed R1.

On 5/4/21 at 10:17 am V7 (Certified Nursing Assistant- CNA) said, "I heard (R1) and (R2), they have an argument. (R2) was giving (R1) a hard time about the over-head light being on. I went there right away but when I reached their room (R1) was already on the floor. "

On 5/4/21 at 8:04am, V3 said that "The reason I thought they (R1 and R2) need to be separated

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S9999	Continued From page 2	S9999		

was because of the light issue. " V3 was asked if the pushing incident could have been prevented if one of them has been transferred to another room, V3 said, "Maybe, if they have been separated in different rooms. At night time they have an issue with the lights." V3 also said, "I told the morning nurse (V4-RN), that they have issue at night time, the recommendation, on my mind, they should be separated. I do not think I told the DON (Director of Nursing), I only reported it to (V4) the morning nurse."

On 5/3/21 at 2:13pm, interview with V4, she said that there was one report that she received from V3 about the issue between R1 and R2 during the night.

R2's Progress Notes entered by V3 dated 1/1/21 stated in part; "In the night complaints about the roommate (R1) that he is dirty not flushing toilet keep the light on. (R2) will scream at (R1) and there will be arguments between them. This night also there was some arguments between them. These residents needs to be separated in different rooms."

R1 was sent to the hospital, and medical record (X-ray dated 1/1/21) stated in part; Findings: Impression: Non displaced fracture of the greater trochanter.

A facility incident investigation dated 1/6/21 sent to state agency stated in part; Conclusion: "Through investigation completed. Based on the information we received through interviewing the staff, (R2) and (R1), it has been substantiated that (R2) did push (R1) causing him to fall."

B

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