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 11/01/2021

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 Facility Reported Incident of September 19, 2021/IL138710	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.1210c) 300.1210d)6) Section 300.1210 General Requirements for Nursing and Personal Care c) Each direct care-giving staff shall review and be knowledgeable about his or her residents' respective resident care plan. d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour, seven-day-a-week basis: 6) All necessary precautions shall be taken 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. These requirements were not met as evidenced by: Based on observation, interview, and record review, the facility failed to safely turn a resident during incontinence care for one of three residents (R1) reviewed for falls in the sample of three. This failure resulted in R1 rolling out of bed	S9999	Attachment A Statement of Licensure Violations	

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S9999	Continued From page 1 onto the floor and sustaining a scalp laceration requiring an emergency room visit and staples. Findings include: R1's Face sheet documents R1 with a diagnosis of cerebral infarction. R1's quarterly fall assessment, dated 7/22/21, documents that R1 is a high risk for falls. R1's current Physician Order Sheet and Care Plan documents R1 is on a low air loss mattress. R1's Minimum Data Set (MDS), dated 7/27/21 documents R1 requires extensive assistance for bed mobility. R1's current care plan documents R1 has impaired mobility and needs physical assist with bed mobility due to "decreased endurance/strength; cognitive/memory deficit; limited ROM (Range of Motion); impaired voluntary movement on right side; decreased trunk mobility/control; and pain/discomfort." This same care plan documents R1 to roll side to side in the bed with verbal cues and extensive assist of one to two staff with an approach of "instruct and provide assistance to hold onto the rails when turning/repositioning (R1) to side." R1's "Device Evaluation" form, dated 9/20/21, documents an initial evaluation was completed to assess R1 for a right sided mobility device. This same form documents the right sided mobility device is "new" and the indication for use of the right sided mobility device is documented as safely assist resident with bed mobility and transfers and poor balance or trunk control.	S9999		

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S9999	Continued From page 2 R1's Therapist Progress and Discharge Summary, signed and dated by V11 (Physical Therapist) on 8/19/21, documents R1's ability to roll left and right as "Dependent" and "Helper does ALL of the effort. (R1) does none of the effort to complete the activity or the assistance of two or more helpers is required for the resident to complete the activity." This same form documents the "Analysis of Functional Outcome/Clinical Impression" as (R1) requiring "extensive assistance" for bed mobility task of rolling side to side due to bilateral lower extremity weakness and that R1 has reached R1's maximum potential. R1's "Final Report of Incident" to the local state agency, dated 9/22/21, states, "Describe nature of incident: Fall with injury. On 9/19/21 at 1:30 P.M., (R1) was receiving care and turned to (R1's) right side and rolled off the bed. Open area noted to left side of head and (R1) complained of back pain. Pressure dressing applied to the head. Physician notified and 911 was called. POA (Power of Attorney) notified of the incident. Investigation started immediately. Summation of findings: (R1) returned to the facility (from the local area hospital) later in the evening on 9/19/21. (R1) has four staples in place to the left side of (R1's) head. X-ray and CT (Computed Tomography) were negative. (R1) is alert times 1-2 and stated, 'It was just a freak accident I started rolling and couldn't stop myself.' (R1) was receiving care during this time and the staff member (V4/Certified Nursing Assistant) was on the left side of the bed providing care. (V4) was unable to hold (R1) and keep (R1) from rolling off the right side of the bed. After thorough investigation and review of medical records it has been determined that while receiving care (R1) rolled off the side of (R1's) bed and hit (R1's)	S9999		

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S9999	Continued From page 3	S9999		

head during the fall. (R1) was not hospitalized and remains at the facility. (R1's) plan of care has been reviewed and updated."

R1's "Level One Root Cause Analysis" form, dated 9/19/21, states, "8. Was the resident using an assistive device?" The response is marked as "No". This same report also states, "Based on the above information, what interventions are most appropriate?" The facility response is documented as "Need floor mattress and assistive devices on right and left side of the bed."

R1's "Resident Incident Report" dated 9/19/21, documents R1 had a fall in R1's room resulting in R1 being sent to the local area hospital with injury. This incident was reported by V4 (CNA) to V5 (Registered Nurse). This same form states, "(R1) was on air mattress. (V4) stand left side of (R1's) bed and turned (R1) to the right side of the bed to clean and change the wet linen and diaper at that time (R1) rolled over from the bed to the floor on (R1's) back to the right side of the bed. Bed was in low position. Laceration on back of head with bleeding, c/o (complains of) back pain. Immediate actions taken: Ice pack applied to lacerated area, Dry dressing applied to stop bleeding, vital signs taken. Called 911."

R1's "Incident Witness Statement Form" signed and dated by V4 on 9/19/21 states, "(R1) was laying on her right side in the bed, as I was changing her diaper. (R1) she slipped off the mattress and rolled off the bed onto the floor. I was on the left side of the bed. (R1) rolled off on the right side of the bed."

On 10/31/21 at 9:50 A.M., R1 was lying in bed on an air mattress. R1 stated R1 fell recently and

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S9999	Continued From page 4	S9999		

required four staples to R1's head. R1 does not recall further details regarding the incident.

On 10/31/21 at 9:57 A.M., V6 (Registered Nurse/RN) stated, "If I was turning a resident alone, I would turn them towards me, so they don't fall out of bed."

On 10/31/21 at 9:58 A.M., V5 (RN) stated, "The CNA that was changing (R1) came to me and said that (R1) had rolled out of the bed. (R1) was on an air mattress with no side rails. I called 911 because there was a laceration to the left side of (R1's) head. (R1) needed four staples (to the laceration)." At this same time, V5 also stated, "I would always turn a resident towards me if I was alone. There is only one device there (on R1's bed), that's the problem."

On 10/31/21 at 10:20 A.M., V7 (Certified Nursing Assistant/CNA) stated, "I would always make sure to have two people when turning a resident during incontinence care, especially with an air bed. If I was turning a resident on my own, I would always turn the resident towards me, so they don't fall off the bed. It's how we are trained."

On 10/31/21 at 10:22 A.M., V8 (CNA) stated, "I would always turn a resident towards me if I was alone. It's easy for them to just keep going and land on the floor, especially on an air mattress."

On 10/31/21 at 10:35 A.M., V2 (Director of Nursing) stated, "It's in all of my training that if you're turning a resident by yourself; that you would turn the resident towards you to prevent them from rolling out of the bed."

On 11/1/21 at 9:12 A.M., V11 (Physical Therapist) stated it is "common sense" to turn a resident

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S9999	Continued From page 5 towards you if you are turning a resident alone. On 11/1/21 at 9:15 A.M., V9 (Physical Therapy Assistant) stated R1 has weakness, rigidity, limited ROM, is contracted, and doesn't want to move a lot due to pain it causes. V9 stated it is always safer to use two staff members when turning and repositioning residents in bed and to turn the resident toward you if you are turning a resident alone. On 10/31/21 at 9:40 A.M., V3 (Assistant Director of Nursing) verified R1 was turned away from V4 when V4 was providing cares and that R1 did not have a mobility aid on the side of the bed that R1 was turned towards. V3 stated the right mobility aid was added to R1's bed after R1's 9/19/21 fall. V3 also verified when turning a resident alone, the resident should be turned towards the staff member to reduce the risk of falling. V3 stated, "It would make sense." On 10/31/21 at 12:11 P.M., V3 stated that if V4 had used another staff member to assist turning R1 during the incontinence care for R1, R1's fall may not have occurred. Repeated calls with messages left to V4 were not returned. (B)	S9999		