Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6014575	A. BUILDING: ______ B. WING ______	C 03/09/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASCENSION RESURRECTION LIFE	7370 WEST TALCOTT AVENUE CHICAGO, IL 60631

(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 January 31, 2022/IL143468	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.1210 b) 300.1210 c) 300.1210 d)6) Section 300.1210 General Requirements for Nursing and Personal Care b) 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. 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. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility	S9999	**Attachment A** **Statement of Licensure Violations**	

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S9999	Continued From page 1 failed to provide adequate supervision to R1. This failure resulted in R1 sustaining a fall which required R1 to go to the hospital due to sustaining a laceration with bleeding to the back of the head, requiring 5 staples. Finding includes: According to a face sheet, R1's diagnoses include Contracture, Rhabdomyolysis, Pressure Ulcer, Open Wounds, Neuromuscular Dysfunction of bladder, Dementia, Severe protein malnutrition and Acute kidney failure. R1's Minimum Date Set assignment dated 9/15/21, indicated R1 has a Brief Interview for Mental Status (BIMS) score of 8, which indicates resident has moderate impairment. Facility's Final Report of R1's Incident (2/4/22) documents in part: On January 31, 2022, at about 4:45 am the resident was found lying on the left side of the bed after CNA (Certified Nurse Assistant) heard a thud. The resident was alert and oriented to self-unable to relate what happened, VS BP 92/50, PR 70 RR 18 T 97.6 in no apparent distress and able to move limbs, verbalized pain to back of R1's head where bleeding was noted. Ice pack applied, and pressure to site. Neuro check performed and WNL (Within Normal Limits). Sent to "emergency room" via EMS (Emergency Medical Services) for further management. Investigation: On the day of the event, an agency CNA was providing incontinence care to R1 and turned R1 to R1's left side, in bed with a pillow on the side for support. He noted the soiled dressing to R1's coccyx and decided to call the nurse's attention so it can be changed. He verbalized first walking to the door and then walking to the	S9999		

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S9999	Continued From page 2 nurse's station a few steps away to find the nurse when he heard a thud. He found R1 on the floor at the left side of R1's bed. Nurse and supervisor notified and provided assistance. R1 was not able to relate what happened and blood was noted on the floor from the back of R1's head. Ice pack and pressure applied to site and 911 called. Physician, POA (Power of Attorney) and hospice also notified. Resident was sent to the ED and 2 cm scalp laceration was repaired with 5 staples. CT scan of the head and spine was performed with negative results. R1 returned to the facility at 6:10 pm via superior ambulance resuming hospice care. On 3/7/22 at 9:48 am V2 (Director of Nursing) said she is new to the facility. V2 said, V3 (Certified Nursing Assistant) was assigned to R1 and is an agency employee. V2 said, on 1/31/22 V3 (CNA) was changing R1, he was doing incontinence care. R1 had a bowel movement and there was stool over R1's dressing (R1 had a wound). V2 said, V3 went to get the nurse, V4 (Registered Nurse/RN) to tell her the dressing was soiled and needed to be changed. V2 said, when V3 and V4 returned to the room, R1 was found on the floor. V2 said, facility does not have side rails or bed rails for their residents. V2 said, floor mats were intervention that was added after R1 fell. V2 said, R1 was laying on R1's back towards the left side on the low air loss mattress and R1 was not in the center of the bed. V2 said, it was not appropriate to leave a resident on a low air loss mattress like this because the mattress deflates on one side. V2 said, the bed should be left in low position and V3 (CNA) should have made sure the resident was in a safe space before he left the resident alone. V2 said, the call light was with the resident and V3 should have turned the call light on for the nurse to come to	S9999		

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S9999	Continued From page 3 the room instead of leaving the resident. V2 said, facility has been trying to get in touch with V3, but he has not been answering his phone. The facility only got a statement from V3 the day of the incident. V2 said, all she knows is that the bed was not in the lowest position when R1 was found, and she does not know how high the bed actually was and R1 was left by V3 turned to the left side and not in the center of the low air loss mattress. On 3/7/22 at 10:37 am V4 (RN) said, that morning, V3 called her attention right before she was about to do her morning medication pass, that he needed help with R1 regarding the dressing on R1's back, it had to be changed because it was soaked. V3 informed V4 he was changing the resident's brief and noticed R1's dressing was soiled. V4 said, V3 ran out of the R1's room to tell V4 about the dressing and V4 asked "why you left the resident unattended" however V3 insisted she will go and change R1. V4 said, they heard a sound in R1's room and both ran to R1 and found R1 was on the floor. V4 said, she was so mad she told V3 "see what did you do, you left the patient alone and (R1) fell". V4 said, V3 was sorry for what happened. R1 was lying on the floor, the bed was regular height, it was at working level and not all the way to the floor. V4 said, before V3 left R1's room, he did not put the bed to the floor and anyway the dressing could have been changed later. V4 said, R1's head was bleeding, she assessed the resident, did vital signs and called 911 because R1 needed to be send to the hospital. V4 said, V3 did wrong, he left the R1 unattended, and the bed was not in the lowest position. V4 said, according to V3, R1 was left on the edge of the bed, on the left side when V3 left the room. V3 said, V4 barely answered any questions to what happened. R1	S9999		

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S9999	Continued From page 4	S9999		

was on a low air loss mattress, and the resident should be centered and not left on the edge of the bed, otherwise the bed is not balanced. V4 called R1's doctor to inform him the resident was found on the floor and was bleeding. V4 said, V3 left R1 unattended, without safety in place, R1 should not be left turned on the side, not in the middle of the bed and the bed should have been in the lowest position.

On 3/7/22 at 10:53 am V2 said, R1 came back with staples 5 to the back of the head. The resident should have been left in the middle of the mattress. V2 said, residents on a low air loss mattress, can be tilted to the side, wedge can be used but the residents body needs to be in the middle of the bed. Because of the way the mattress works, it deflates when there is pressure applied to it, and residents body keep moving and resident can fall out of the bed if the resident is too close to the edge of the bed.

On 3/7/22 at 11:03 am V3 (CNA) said, he was doing rounds, was providing incontinence care to R1 and noticed R1's soiled, he worked the night shift, and it was busy. V3 said, before he left R1's room to find V4, he lowered the bed but not all the way down. V3 said, he came out of the room and was calling for V4 to change the dressing. V3 said, before he knew the resident fell out of the bed and he came in with the nurse and found R1. V3 said, he believes he left R1 in the middle of the bed. V3 said, he did not press the call light to get V4's attention, and that was a mistake. V3 said, R1 was left alone for no more than 60 seconds.

On 3/8/22 at 4:37 pm, V5 (R1's Physician) stated on 1/31/22 facility called him to make him aware there was an incident involving a CNA (Certified

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nursing Assistant) and R1. V5 said, he does not know the entire circumstance with the incident but does know that R1 slid off the bed. V5 said, the height of the bed was not an issue to V5, but R1 was left unattended and R1 had a poor postural balance. Meaning if R1 was left on R1's side, and R1 started to roll over, R1 would not be able to stop from falling. V5 said, the height of the bed would make a difference to what kind of injuries the resident would have when falling. V5 further said, low air loss mattresses are slippery and if a resident is left on their side and not in the middle of the bed they can slip from the bed.

R1's (1/31/22) progress note by V4 (RN) documents in part: Resident head on the floor, noted with bleeding at the back of R1's head.

R1's (9/21/21) "Care Plan" documents in part: Resident is at risk for falls due to generalized weakness secondary to rhabdomyolysis, wound infection, malnutrition, history of falls- Place bed in lowest position safe for resident and wheels locked.

R1's (1/25/22) "Care Plan" documents in part: Resident needs assistance with ADLS due to impaired mobility and weakness.

R1's (9/9/21) "Physician Orders" document in part: Fall Precaution.

Facility's "Falls Prevention" program documents in part:
c. the documentation of the identified interventions should be maintained in the resident clinical record and available to the direct care associates.

Facility's "certified nurse assistant" job

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S9999	Continued From page 6 description, documents in part: Assures resident safety by identifying safety hazards. "B"	S9999		