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
	IL6007892	A. BUILDING: ___ B. WING ___	C 02/29/2024

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 10/13/24/IL169896	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.1210b) 300.1220b)3) 300.3240a) Section 300.610 Resident Care Policies a) The facility shall have written policies and procedures governing all services provided by the facility. The written policies and procedures shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee, and representatives of nursing and other services in the facility. The policies shall comply with the Act and this Part. The written policies shall be followed in operating the facility. 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.	S9999		

Illinois Department of Public Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE — (X6) DATE

Electronically Signed — 03/18/24

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300.1220 Supervision of Nursing Services

b) The DON shall supervise and oversee the nursing services of the facility, including:

3) Developing an up-to-date resident care plan for each resident based on the resident's comprehensive assessment, individual needs and goals to be accomplished, physician's orders, and personal care and nursing needs. Personnel, representing other services such as nursing, activities, dietary, and such other modalities as are ordered by the physician, shall be involved in the preparation of the resident care plan. The plan shall be in writing and shall be reviewed and modified in keeping with the care needed as indicated by the resident's condition.

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 requirements were not met as evidenced by:

Based on observations, interviews, and record reviews the facility failed to follow their policy and procedures for abuse prevention by not ensuring an agency staff received a thorough criminal background check, not identifying a resident's behaviors that increase their risk for abuse, and not ensuring an abuse risk or behavior care plan was developed for a resident with a history of refusing care. This failure applied to one of one (R1) resident reviewed for abuse and resulted in R1 being physically and verbally abused and sustaining physical and psychosocial harm.

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Findings include:

R2 is an 87-year-old female with a diagnoses history of Cerebral Infarction, Aphasia, Partial Paralysis due to Cerebral Infarction, Dysphagia, and Adult Failure to Thrive, and Major Depressive Disorder who was admitted to the facility 07/08/2020.

On 02/26/2024 from 2:38 PM - 2:55 PM Observed R2 in her room sitting up in her bed with her head down in front of a meal tray laying on a bedside table over her bed. Observed R2 could not communicate verbally. Observed R2 to communicate through gestures, nods, and sounds. Observed R2 push her tray towards surveyor not wanting to eat it. Observed R2 to be agitated and nearly knocking her tray to the floor before surveyor caught it. Surveyor handed R2's tray to V25 (Agency Certified Nursing Assistant). V25 stated R2 is not interested in eating her meal. V25 stated R2 is highly agitated and is often that way. Observed R2 exhibit agitation in the form of pulling her call light button and bed remote aggressively towards her chest and gesturing and making sounds indicating refusal of V25's offers when attempting to adjust her bedside table and ask what her needs were. Observed V25 plug back in R2's call light. V25 stated R2 pulls out her call light. Observed R2 press her call light multiple times. Observed V10 (Unit Secretary) respond to R2's call light. Observed V10 redirect R2 not to try and get out of her bed. Observed R2 respond to V10 with head nods and pointing in an agitated manner when being redirected. V10 stated she had been to R2's room at least 8 times because she keeps pressing the call light.

R2's social service progress note dated

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10/13/2023 documents upon notification of immediate care concern social services contacted V29 (Family Member) regarding nature of concerns. V29 reports that V29 understands R2 does refuse care at times and can be a "little tough to deal with since her stroke."

R2's Full Care Plan does not include refusal of care or behaviors. R2's Care plan initiated 05/23/2023 documents R2 is experiencing new symptoms of depression without a description of what those new symptoms of depression are with interventions including observe R2 for changes in mood status.

Incident Investigation report dated 10/13/2023 documents on 10/13/2023 two student CNA's (Certified Nursing Assistant) who were at the facility notified their instructor they witnessed a CNA being rude to R2 while giving her care. The instructor notified the DON (Director of Nursing) around 2:30 PM. The alleged CNA V19 (Agency CNA) was interviewed by the Director of Nursing and Administrator and denied hitting R2. During a head-to-toe assessment R2 was observed with a fading light purplish skin discoloration on the right wrist with a surrounding yellow hue, a dried scab was also noted on R2's right forearm. R2 is unable to communicate verbally, has right sided partial paralysis due to stroke. R2 is interviewable and through non-verbal communication indicated V19 hit her on the arm and began to cry. An order for x-ray of right wrist was given and was negative for fracture or dislocation. The two CNA students who witnessed the incident were interviewed by the administrator and the director of nursing along with the clinical instructor. V21 (Student Certified Nursing Assistant) reported he observed CNA strike R2 multiple times on R2's forearm and observed the CNA asking R2, "why are you

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S9999	Continued From page 4 always like this. Do you want me to leave you?". V21 stated V21 observed the CNA laughing at the resident causing her to cry. V20 (Student Certified Nursing Assistant) reported he did not observe the CNA hitting R2. The CNA did not assist R2 with getting out of the toilet and "used force to make her get up." Law enforcement was notified, and a report was made. It was concluded that based on R2's interview and witness interviews from V20 and V21, the facility can substantiate physical abuse by V19 and V19 is no longer working at the facility. Witness statement dated 10/13/2023 from V20 (Student Certified Nursing Assistant) documents he observed the CNA be very rude towards R2 including laughing at her when she struggled on the toilet, not helping her properly transfer from toilet, using force to make her get up, continuing to force her to get up while she screamed in pain. R2 was very upset after all that occurred. Witness statement dated 10/13/2023 from V21 (Student Certified Nursing Assistant) documents the CNA struck R2 multiple times on her forearm, insulted her stating, "Why are you always like this?", and threatened R2 stating "Do you want me to leave you?" Serious Injury Incident Report dated 10/13/2023 documents R2 was the victim of alleged abuse, Agency Certified Nursing Assistant V19 was terminated. V19's (Agency CNA) Personnel file reviewed 02/28/2023 does not include IDOC (Illinois Department of Correction) criminal background check, or Fingerprinting background check. On 02/29/2024 at 9:44 AM V1 (Administrator) stated agencies complete background screens	S9999		

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S9999	Continued From page 5 but not fingerprints for their staff. V1 stated the facility does not have a policy for screening agency staff. V1 stated the staffing coordinator reaches out to agencies for staffing and there is a coordination with leadership to bring in the right staffing to the building. V1 stated most of the agencies have a platform where you can find background information for all the staff who have been screened and credentialed. V1 stated all the screening information available from the agency for V19 was in his personnel file. On 02/29/2024 at 11:26 AM V1 (Administrator) stated social services handles completing abuse risk assessments for residents. V1 stated if a resident is determined to be at risk for abuse, they should be care planned for abuse risk. V22 (Director of Quality Control/Registered Nurse) stated the facility educates staff regarding abuse and neglect so he doesn't believe there is anything further that could have been done to prevent the abuse incident for R2. V22 and V3 (RN/Nurse Manager) stated they conducted a background check on V19 (Certified Nursing Assistant) and there is no way to tell if a staff member is going to be abusive to residents. On 02/29/2024 at 12:08 PM V26 (Social Services Director) stated there are no assessments to determine if residents are at risk for abuse. V26 stated if we determine a case of abuse took place on site social services would do a screening to determine if any other residents were at risk for abuse. V26 stated abuse risk assessments are performed as needed. V26 stated risk factors that would increase a resident's likelihood of being abused include a psychiatric history of being abused, history of substance use, any behaviors such as anxiety, anger, fear, withdrawn behavior. V26 stated all the social factors that involve a	S9999		

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S9999	Continued From page 6 history of abuse would be the same social factors that would potentially increase a resident's risk of being abused especially if there are changes in a resident's behavior. V26 stated agitation would not necessarily be a risk factor of abuse. V26 stated if a resident has an indicator of agitation which is a comorbidity of mental illness that would not necessarily be a risk factor for abuse. V26 stated R2 has periods of refusing care, can be agitated at times, and has a diagnosis of major depressive disorder. V26 stated when R2 is agitated she refuses care at times, presents with a sad affect, exhibits anxiety all of which are part of her mental status and would not necessarily be an indicator or risk factor for abuse. V26 stated when R2 refuses care it presents as agitation, combativeness, not wanting to be bothered, pushing things away if you try to hand them out to her, sometimes she pretends to sleep. V26 stated these have been her personal observations of R2. V26 stated she doesn't want to believe that R2's behaviors could lead to abuse because that would be very concerning. V26 stated a behavior care plan is developed for resistance to care. V26 stated one instance of exhibiting these behaviors would not warrant a care plan, multiple observations would be required before it is care planned. V26 stated if there is a care plan missing regarding R2's refusal of care it would possibly be because she is still under observation for those behaviors, and we complete quarterly updates to care planning. V26 stated within that quarter there would need to be at least three observations of this behavior before it is care planned. V26 stated behavior observations can be communicated verbally or in writing. On 02/29/2024 at 2:06 PM V29 (Family Member) stated R2 had a stroke and has these seizures and there's times where she can be mean which	S9999		

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is usually during the times seizures come. V29 stated R2's been this way a number of years. V29 stated R2 had a stroke 23 years ago. V29 stated the facility has reported to him periodically that R2 refuses care at times and one of the most recent reports of this was three or four months ago. V29 stated he would say R2's refused care a few times over the course of the years she's been there. V29 stated he used to be able to have some influence over this behavior and calm her down when he was able to visit her more consistently. V29 stated he would redirect R2 not to behave that way.

The facility's Abuse Prevention Policy received/reviewed 02/28/2024 states:
"Our residents have the right to be free from abuse. The objective of the abuse policy is to comply with the seven step approach to abuse detection and prevention."
"The community's goal is to achieve and maintain an abuse-free environment. As part of the resident abuse prevention program, the administration will provide a safe resident environment and protect the residents from abuse by anyone including, but not limited to: community associates, associates from other agencies."
"It is the policy of this community to screen employees and volunteers prior to working with residents. Screening components include verification of references, certification and verification of license and criminal background check. Will not knowingly employ or otherwise engage any individual who has: Been found guilty of abuse or mistreatment by a court of law; Had a finding entered into the State nurse aide registry concerning abuse or; Had a disciplinary action in effect against his or her professional license by a state licensure body as a result of a finding of

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S9999	Continued From page 8 abuse or mistreatment of residents." "The community will provide training for associates at new hire orientation and through ongoing programs that include, but not limited to, such topics as: Understanding behavioral symptoms of residents that may increase the risk of abuse and neglect and how to respond. These symptoms, include, but are not limited to, the following: a. Aggressive reactions of residents; c. Resistance to care." (B)	S9999		