STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ASL510280	A. BUILDING: _____ B. WING _____	C 04/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASCENSION LIVING RESURRECTION VILLAGE	7262 W PETERSON AVE 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
A 000	Initial Comment Annual Licensure Survey Conducted: 295.4010 Facility Reported Incident: #178444-Refered to SNF #181070-Substantiated 295.4010 Complaint Investigation: #184929-Unsubstantiated	A 000		
A4010	Section 295.4010 Service Plan This Regulation is not met as evidenced by: General Violation Section 295.4010 Service Plan a) Based on the physician's assessment and establishment evaluation (see Section 295.4000), a written service plan shall be developed and mutually agreed upon by the establishment and the resident. (Section 15 of the Act) The establishment shall respect and accept the resident's choices regarding the service plan. b) d) The service plan, which shall be reviewed annually, or more often as the resident's condition, preferences, or service needs change, shall serve as a basis for the service delivery contract between the provider and the resident (see Section 295.2030). (Section 15 of the Act) e) The service plan shall be reviewed and revised if necessary immediately after a significant change in the resident's physical, cognitive, or functional condition (see Section 295.4000).	A4010		

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A4010	Continued From page 1 These Requirements are not met as evidenced by: Based on interview and record review, the facility failed to develop, update and implement fall service plans which incorporated assessment and recommendations from physical therapy, addressed current fall risk factors, followed facility fall policy and procedure and protected 3 residents(R1, R2, R3) out of 3 residents from injury due to fall in a total sample of 3. As a result of facility failure, R1 fell on 11/10/24 requiring stitches, R2 fell on 10/18/24 resulting in left femur fracture, and R3 fell on 2/16/25 while ambulating along in the hallway leading to fracture with surgery. Findings include: R1 was admitted to assisted living on 12/1/23 and transferred to the hospital on 2/11/25 after noted with dark urine on 2/10/25 and increased tiredness. R1 did not return to the facility after this transfer. Prior to facility move-in R1's medical history included a right hip fracture on 11/2/23, falls, Basal cell carcinoma, recurrent urinary tract infections, hypertension, constipation, osteopenia, and hypertension. Born on 12/27/1932, R1 is 92 years old. R1 fall risk assessments dated 6/24/24 and 11/10/24 describe R1 respectively as "unable to ambulate independently," and "unsteady gait with walker." R1 is scored as having moderate risk of fall based on fall assessment. R1's nursing notes document falls on 6/24/24 at 5:00 am and 11/10/24 at 11:45 am in the dining room. The 6/24/24 fall which was unwitnessed in R1's room resulted in stitches to the left forehead.	A4010		

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A4010	Continued From page 2	A4010		

The 11/10/24 fall was witnessed. R1 was ambulating without assistance and stepped sideways to get into seat and fell resulting in stitches to the right eye and a subarachnoid hemorrhage.
Prior to the fall of 11/10/24 which resulted in injury, R1 on 11/6/24 had been discharged from skilled physical therapy. Documentation from physical therapy dated 11/6/24 or 4 days prior to fall with injury, describes R1 as needing VC(verbal cues) and TC(tactile cues). R1's fall with injury, service plans and physical therapy recommendations were reviewed with E2(Director of Nursing). On 4/23/25 at 2:00 pm, E2(Director of Nursing) stated in part, "Reason for physical therapy weakness and balance. No 2024 Service Plan, only 11/30/23 and 2/20/25. 11/30/23 (R1) moderate standby or 1 assist. Stand in front or next; definitely someone in front of (R1) as needed."
Facility failed to follow R1's physical therapy recommendations for verbal cues and tactile cues resulting in inadequate assistance during ambulation and movement into chair for lunch on 11/10/24 at 11:45 am. This failure led to a fall with injury for R1 on 11/10/24.
R2 was admitted to the assisted living facility on 2/23/24 with diagnoses listed in the facility clinical record of Vascular Dementia (10/24/23), Diastolic and Congestive Heart Failure, cardiomyopathy, Diabetes, and neuropathy. Born on 1/28/1941, R2 is 80 years old. At the time of this review, R2 was in isolation for covid. R2 declined to be interviewed due to fatigue. On 4/25/25 at 9:55 am, R2 was resting in bed.
Fall risk evaluation of 2/23/24 and 7/2/24 describe R2 as "ambulates without problems and with devices (walker)." However, fall risk score is 9 and 7 respectively or "higher risk" for falls. Brief interview for mental status on 7/2/24 equals 11

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A4010	Continued From page 3 out of possible 15 indicating moderate cognitive impairment. Nursing notes describe R2 as "alert and oriented x2 (4/3/24, 9/28/24)," needing one person for "activity of daily living assistance (6/6/24, 10/16/24)." On 8/12/24 R2 has symptomatic hypotension with Blood Pressure of 90/42 and is sent to the emergency room. There is no diagnosis or additional available information related to this hospital visit but the next nursing note in Assisted Living is dated 9/25/24 and refers to associated skilled care stay pre return to Assisted Living. On 9/25/24 the assisted living nurse records the presence of a stage 2-1 x 2 cm wound on the right side of R2's buttock. R2 returns to the emergency room for unknown reason on 9/25/24. The presence of a buttock wound is the only change in status mentioned in the 9/25/24 nursing note prior to being sent out to the emergency room. R2 returns the evening of 9/25/24 with the next nursing note describing a fall on 10/18/24 at "around 6:30 am" in her room. Accident/Incident report of 10/18/24 describes R2 as "alert and oriented x 2 ...uses a walker for ambulation ...provides ADL(activities of daily living) to themselves. Calls for assistance ..." Resident assistant "observed (R2) on the floor on her left side, near the bathroom door in (R2) apartment, and (R2's) walker was observed nearby ..." R2 was sent emergently to the hospital after complaining of pain to the left thigh and admitted with "a fracture to the left femur." R2's ability to provide activities of daily living care independently as recorded in the accident/incident report is not consistent with nursing notes or physical therapy notes. The call for assistance documented in the accident/incident report occurred after the fall and based on physical therapy note review, R2 was requiring both verbal and manual guidance for	A4010		

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A4010	Continued From page 4	A4010		

proper performance of functional activities prior to the fall with injury.
During review documentation suggesting R2 was receiving physical therapy was found.
E2(Director of Nursing) was asked for a copy of the physical therapy note which was not found in the clinical record. E2 did not have a copy of the physical therapy notes and had to request them.
Based on review of 10/16/24 note or 2 days before a fall with fracture, Z1(Physical Therapist) writes, R2 "needs assist with ambulation" and has functional limitations in "ROM/Strength (range of motion), safety techniques, Balance/gait, transfer, bed mobility" and is at "increased fall risk." On the 2nd page of this document, Z1 notes R2 needs, "manual guided movements required for correct execution of activity," and "completed sit to stand with augmented feedback for proper task execution."
R2's physical therapy assessment of functional limitations triggering both cueing and "manual guided movements" are not included in R2's undated but active service plan forwarded by E2(Director of Nursing). Under activities of daily living heading, R2's service plan lists transfer and mobility as "no assist needed." The only activity of daily living in which minimal assistance is needed is in bathing and evacuation otherwise R2 based on service plan is independent.
R2's service plan and physical therapy notes were discussed with E2 on 4/25/25 at 11:00 am. E2 based on review of physical therapy notes recognized the "service plan had no assistance needed but physical therapy wrote on 10/16/24 "needs assist with ambulation," and R2 had not been instructed to call for assistance prior to getting up. The failure to incorporate physical therapy recommendations and educate R2 in the need for assistance before ambulation resulted in a fall with injury. E2 recognizes R2 "should have

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A4010	Continued From page 5	A4010		

been minimal/moderate assist contact guard."
As late as 10/18/24 R2's fall risk assessment is scored as "ambulates without problem and with devices." The completed fall risk assessment is not capturing the deficits physical therapy related to R2's function.
R3 was admitted to the facility on 1/27/25 with diagnoses of Osteoarthritis, Dementia, Abnormal gait/mobility, Chronic Kidney Disease, hypertension, and weakness. Born on 2/17/1924, R3 is 101 years old. Brief interview for mental status on 1/21/25 is scored as 9/15 or moderate cognitive impairment.
Assistive device safety evaluation of 1/27/25 documents "history of fall in the past 6 months" and "resident is able to safely and appropriately use walker prior to admission." However, additional assessments performed in the facility including fall risk assessment and physical therapy document R3 unsteadiness on feet with nursing also referring to confusion on the part of R3.
Fall risk assessment on admission to facility includes notation of "unsteady gait." Fall risk assessment for day of admission, 1/27/25 assesses R3 as "ambulates with problems and with devices." Handwritten remark next to mobility documents "unsteady gait."
Nursing note of 2/1/25 describes R3 as "anxious with memory impairments. Registered Nurse assessed resident who reports feeling confused. Is forgetful."
R3 underwent physical therapy evaluation on 2/12/25 but during record review, physical therapy notes could not be found. E2(Director of Nursing) was asked for notes and stated she would need to request from P.T.
Based on review, 2/12/25 physical therapy evaluation documents R3 "presents with instability and general weakness in performing

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A4010	Continued From page 6 functional activities as noted gait pattern discrepancies ...cga (contact guard assist) for 50 feet with 4-wheel walker." Although physical therapy has assessed R3 as needing contact guard assist, R3 falls with injury while ambulating independently in the hallway. By 2/16/25 at 9:20 am R3 has fallen while ambulating alone in the hallway resulting in (left)femur fracture and leading to surgery on 2/17/25. E2(Director of Nursing) acknowledged R3 should have been a contact guard assist in the service plan while ambulating given physical therapy findings and recommendations. As a result of facility failure to provide R3 with ambulation assistance given R3's gait impairment and fluctuating mental status, R3 fell on 2/16/25 resulting in a femur fracture. Facility fall policy and procedure in part has the purpose to identify interventions based on previous evaluations and current data, to try to prevent the resident from falling and to try to minimize complications from falling. Interventions should be implemented based upon medical record review, physical assessments, fall risk evaluation and safety evaluation. Identified interventions should be maintained on the resident Service Plan and available in resident care guides for the direct care associates. Facility failed to follow fall policy and procedure resulting in resident harm.	A4010		