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	ASL510277	A. BUILDING: _____ B. WING _____	10/14/2025

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ASCENSION LVING BETHLEHEM WOODS VILLAGE	1529 W OGDEN AVE LA GRANGE PARK, IL 60526

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A 000	Initial Comment Annual Licensure Survey 295.2040 a) 5) c) d) e) g) h) 295.4010 a) c) d) e) g) 1) 2) 3) 295.4060 a) 2) A) i) - v) B) i) - v) Facility Reported Incident - IL198010/FRI 9.21.25 295.4010 a) c) d) e) g) 1) 2) 3) cited	A 000		
A2040	Section 295.2040 Disaster Preparedness This Regulation is not met as evidenced by: Type 2 Violation Section 295.2040 Disaster Preparedness a) For the purpose of this Section, "disaster" means an occurrence, as a result of a natural force or mechanical failure such as water, wind or fire, or a lack of essential resources such as electrical power, that poses a threat to the safety and welfare of residents, personnel, and others present in the establishment. 5) Orient each resident to the emergency and evacuation plans within 10 days after the resident's arrival. Orientation shall include assisting residents in identifying and using emergency exits. Documentation of the orientation shall be signed and dated by the resident or the resident's representative. c) At least six drills shall be conducted per year on a bimonthly basis. At least two of the	A2040		

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A2040	Continued From page 1 drills shall be conducted during the night when residents are sleeping. All drills shall be held under varied conditions to: 3) Evaluate the effectiveness of disaster plans, procedures and training. d) The establishment shall conduct a tornado drill on each shift during February of each year for employees. e) Drills shall include residents, establishment personnel, and other persons in the establishment. g) Drills shall involve the actual evacuation of residents to an assembly point as specified in the emergency plan and shall provide residents with experience using various means of escape. If an establishment has an evacuation capability classification of impractical, those residents who cannot meaningfully assist in their own evacuation or who have special health problems shall not be required to participate in the drill; however, other requirements of the Life Safety Code will apply. h) A written evaluation of each drill shall be submitted to the establishment manager and shall be maintained for one year from the date of the drill. The evaluation shall include the date and time of the drill, names of employees participating in the drill, and identification of any residents who received assistance for evacuation.	A2040		

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A2040	Continued From page 2 These requirements were not met as evidenced by: Based on record review and interview, the establishment failed to: -within 10 days after their move in, orient 5 of 5 residents (R1, R2, R3, R4, R5) in the sample reviewed for emergency and evacuation plans. The resident handbook does not include assisting the 5 residents in identifying and using emergency exits. The documentation of orientation was not signed and dated by the resident or the resident's representative; -conduct six fire drills since the last annual survey. There weren't any drills conducted on the evening and night shift and no complete evaluation of the 2 drills that were conducted; -conduct the required 3 tornado drills on each shift during February (2025). These failures have the substantial probability to cause harm to all residents in the establishment. Findings include: 1. The clinical records for R1, R2, R3, R4, and R5 were reviewed. On 10/8/25 at 11:30am, E10 (director of clinical services) was asked if resident orientation is done within 10 days of the resident move into the establishment. E10 said they go over the resident handbook but they don't have a checklist per se. No one signs showing that they have had an orientation.	A2040		

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A2040	Continued From page 3 The Resident Handbook presented by E10 does not include a page that has information about assisting residents in identifying and using emergency exits. There is no documentation in the Resident Handbook where it is signed and dated by the resident or the resident's representative. 2. On 10/8/25, E8 (director of facilities) presented the binder that contains fire and tornado drills which showed the following: Fire drills: -10/1/24 at 10:00 - 10:10am, no list of residents who participated and those who need evacuation assistance -11/3/24 at 12:30pm - 12:38pm, 22 residents participated and signed the sign in sheet, however no level of assistance indicated -tornado drill dated 2/28/25 from 8:37am - 8:40am. There is no documentation to show that a tornado drill was conducted during the evening or night shifts if February -tornado drill dated 8/28/25. There is no start or end time indicated on the evaluation sheet On 10/9/25 at 2:25pm, E8 stated, "I just started in July (2025). I noticed that there were some fire drills missing. I did a mock drill in August just to see where the staff was in terms on conducting a drill. Moving forward, we will be on schedule for the tornado and fire drills." On 10/9/25 at 3:30pm, these concerns were shared with E9 (executive director). E9 stated, "the previous facilities director left in February of	A2040		

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A2040	Continued From page 4 this year. We didn't have anyone to conduct the fire dirlls. We did not hire a new director of facilities until July."	A2040		
A4010	Section 295.4010 Service Plan This Regulation is not met as evidenced by: Type 2 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. c) The service plan shall be signed and dated by all individuals involved in its development. 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 5 g) Service plans shall address: 1) The level of service the resident is receiving, including: A) assistance with activities of daily living; 2) The amount, type, and frequency of health-related services needed by the resident; 3) Staff responsible for the provisions of the service plan; These requirements were not met as evidenced by: Based on record review and interview the establishment failed to: -ensure the service plan was signed and dated in a timely manner by all individuals involved in its development for 5 out of 5 residents (R1, R2, R3, R4, R5) in the sample reviewed for service plans; -review and revisd the service plan immediately after a significant change in the resident's physical and functional condition for four out of five residents (R2, R3, R4, R5) reviewed for unwitnessed falls and falls with injury. R2 sustained a zygomatic arch (facial) fracture. R5 had a unwitnessed fall which resulted in a laceration to the back of the head that required 5 staples to that area. These failures have the substantial probability to cause harm to all residents who reside in the establishment.	A4010		

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A4010	Continued From page 6 Findings include: 1. R1 is a 96 year old resident who moved into the establishment 3/19/25. R1 has diagnoses including Cellulitis, Diabetes Mellitus, CKD (chronic kidney disease), Hypothyroidism, Anemia, Right eye blindness and Hard of hearing. R1 has a history of falls. The service plan dated 3/19/25 was signed by E9 (executive director) and E10 (director of clinical services) but not signed and dated by R1 or R1's power of attorney. 2. R2 is a 83 year old resident who moved into the establishment 3/8/25. R2 has diagnoses including Vascular dementia, Major depressive disorder, Anxiety, Adult failure to thrive, Essential Hypertension, TIAs (transient ischemic accidents) and Cognitive communication deficit. The progress notes from June 2025 through September 2025 show R2 had several unwitnessed falls. The progress note dated 9/15/25 shows at 11:23pm, R2 notified the nurse that she fell in front of the elevator. R2 was assisted back to her room where her left cheek was noted swollen. R2 was sent to the local hospital for evaluation and treatment. R2 returned to the community on 9/16/25 at 4:15am. Hospital diagnosis is closed fracture of the left eygomatic arch (facial fracture). The physician's order dated 9/11/25 shows PT/OT(physical therapy/occupations therapy) eval and treat. Diagnosis: Gait abnormal On 10/10/25 at 4:30pm, E10 (director of clinical services said via email that R2 is still receiving PT/OT.	A4010		

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A4010	Continued From page 7 The service plan dated 3/14/25 does not address the closed fracture of the left eygomatic arch or pain management. PT/OT was not addressed to include the name of the agency, frquency or duration of these therapies. There is no correlation ob care between the establishment staff and agency staff addressed. This service plan was not signed by Z3 until 10/8/25, 7 months after move in. 3. R3 is a 86 year old resident who moved into the establishment 2/19/25. R3 has diagnoses including Hypertension, Diabetes Mellitus, and Arthritis. The progress note dated 3/10/25 through 7/9/25 shows R3 had unwitnessed falls on 3/10/25, 5/17/25 and 7/9/25. The progress note dated 5/17/25 shows staff heard R3 yelling out for help. R3 was noted on the floor by the foot of her bed. R3 said she got up, felt dizzy and fell. R3 said she hit her head. R3 also complained of lower back pain and left leg pain. 911 activated. R3 was sent out to the local hospital. At 10:45pm the local hospital notified establishment staff that the admitting diagnoses include sacral fracture and L2 fracture. The progress note dated 7/9/25 shows R3's lifeline was activated at 8am. R3 was observed on the floor by the foot of her bed in a supine position.R3 said she had to go to the bathroom and got out of bed by herself. R3 said she hit her head. Complained of pain to the back of her head. 911 activated. R3 sent to the local hospital for evaluation and treatment. The additional note shows R3 said she felt dizzy	A4010		

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A4010	Continued From page 8 before falling and wasn't sure how she fell. At 2:30pm R3 was admitted to the local hospital, diagnosis tibia fracture. The telephone order dated 8/18/25 orders for R3 to be able to WBAT (weight bear as tolerated). The service plan dated 2/19/25 was not revised with interventions to address the fractures of the sacrum, L2 and the left tibia. The service plan does not address weight bearing as tolerated. This service plan was signed and dated by E10 (resident services director) on 2/20/25. E9 signed but did not date her signature. R3's POA did not sign and date the service plan until 10/3/25. 4. R4 is a 97 year old resident who has diagnoses including Dementia with behaviors, Anxiety, Flat affect, Confusion, Gait abnormality and Venous insufficiency. The service plan dated 12/10/24 was not revised with new intervention after 2 falls 5. R5 is a 96 year old resident who has diagnoses including Depression, Anxiety, type 2 Diabetes Mellitus, Hypertension, GERD Unilateral primary Osteoporosis. Spinal stenosis, Benign Paroxysmal vertigo. R5 has a history of falls The progress note dated 9/21/25 show at 7:10pm, R5 was observed lying on the floor with locked wheelchair in front of the toilet. Bleeding noted from the back of the head. 911 activated. R5 was sent to a local hospital for evaluation and treatment. At 10:25pm R5 returned from the local hospital, 5 staples applied to back of head	A4010		

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A4010	Continued From page 9 laceration. Staples to be removed 10/1/25 The service plan dated 8/25/25 was not revised with interventions to address care and monitoring for signs and symptom for infection to the laceration.	A4010		
A4060	Seciton 295.4060 Alzheimer's and Demential Programs This Regulation is not met as evidenced by: Type 3 Violation Section 295.4060 Alzheimer's and Dementia Programs - General violation a) In addition to this Section, Alzheimer and dementia programs shall comply with all of the other provisions of the Act. (Section 150(a) of the Act) 2) Staff training: A) All staff members must receive, in addition to the training required in Section 295.3020, four hours of dementia-specific orientation prior to assuming job responsibilities without direct supervision within the Alzheimer's/dementia program. Training must cover, at a minimum, the following topics: i) basic information about the causes, progression, and management of Alzheimer's disease and other related dementia disorders;	A4060		

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A4060	Continued From page 10 ii) techniques for creating an environment that minimizes challenging behavior; iii) identifying and alleviating safety risks to residents with Alzheimer's disease; iv) techniques for successful communication with individuals with dementia; and v) residents' rights. B) Direct care staff must receive 16 hours of on-the-job supervision and training within the first 16 hours of employment following orientation. Training must cover: i) encouraging independence in and providing assistance with the activities of daily living; ii) emergency and evacuation procedures specific to the dementia population; iii) techniques for creating an environment that minimizes challenging behaviors; iv) resident rights and choice for persons with dementia, working with families, caregiver stress; and	A4060		

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A4060	Continued From page 11 v) techniques for successful communication. These requirements were not met as evidenced by: Based on record review and interview, the establishment failed to ensure: -three newly hired direct care employees (E1, E2, E3) completed the required 4 hours of dementia specific orientation prior to assuming job responsibilities without direct supervision; -five newly hired direct care employees (E1, E2, E3, E4, E7) completed the required 16 hours of on-the-job supervision and training within the first 16 hours of employment following orientation. Findings include: On 10/9/25 at 11:35am, personnel files for 8 newly hired employees were reviewed with E9 (executive director). Four of these personnel files showed the following: -E1 (CNA/certified nurse aide), DOH (date of hire) 9/17/24 -E2 (LPN/licensed practical nurse), DOH 8/27/24 -E3 (NA/nurse aide), DOH 5/13/25 -E7 (CNA), DOH 9/16/25 Three direct care employees, E1, E2 and E3, did not complete the required 4 hours of dementia	A4060		

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A4060	Continued From page 12 specific orientation prior to assuming their job responsibilities without direct supervision. E1 and E2 completed 2.5 of 4 hours of dementia specific training. E3 did not show completion of the required 4 hours. Five direct care employees, E1, E2, E3, E4 and E7 did not complete the required16 hours of on-the-job supervision and training within the first 16 hours of employment following orientation. After personnel file review, E9 could not give an explanation why this these new hires did not complete the required hours of dementia-specific training. E9 said E5 (memory care director) should be able to provide the training that the new hires completed. On 10/9/25 at approximately 1:30pm, E5 presented sign in sheets for the Cherished Minds Master Class (the name of the dementia training). The sign in sheet dated 11/19/24 did not include E1, E2, E3, E4 and E7 name. The sign in sheet dated 11/20/24 and 11/21/25 included E1's name. This was approximately 2 months after hire.	A4060		