STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ASL510277	A. BUILDING: _____ B. WING _____	C 05/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASCENSION LVING BETHLEHEM WOODS VILLAGE	1529 W OGDEN AVE LA GRANGE PARK, IL 60526

(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 Facility Reported Incident Investigation Survey of 4/30/25 IL191891- 295.4010d)e) cited.	A 000		
A4010	Section 295.4010 Service Plan This Regulation is not met as evidenced by: General Violation Section 295.4010 Service Plan 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). These requirements were not met as evidence by: Based on interview and record review the establishment failed to implement fall prevention interventions for a resident at risk for falls and failed to update service plans annually and after a fall for 3 of 3 residents (R1, R2 and R3) reviewed for falls in the sample of 3. The findings include:	A4010		

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A4010	Continued From page 1 1.) R1's Service Plan dated 4/23/24 shows she was admitted to the establishment on 3/13/23 has a memory impairment, is high risk for falls with a history of falls and requires a 1 person assist with bathing, toileting and transfers. There is no annual Service Plan for 2025 in R1's medical record. Entered into the 4/23/24 Service Plan is a note dated 4/30/25 showing that R1 had a fall and an aide was standing next to her and witnessed the fall. An Intervention added to that note states "Educate agency staff on how to transfer resident when they are scheduled." R1's 4/30/25 Care Notes show she had a fall at 5:00 PM in the dining area when she missed the chair and landed on her buttocks. At 5:45 PM, R1 complained of neck pain and other discomfort and was sent to a local Emergency Room for evaluation and returned to the facility at 10:20 PM. On 5/23/25 at 9:21 AM, E2 (Director of Clinical Services) said she investigated R1's fall from 4/30/25 and found that an agency staff identified as E6 (Caregiver) had been on the unit with R1 the day of her fall and he failed to walk with R1 and did not pull her chair out for her in the dining room. R1 attempted to pull out her chair to sit and missed the chair and fell backwards. E2 said R1's Service Plan of care shows she is a 1 person assist with ambulating and this could have been avoided if E6 would have walked with R1 and pulled her chair out for her. On 5/23/25 at 10:55 AM, E3 (Certified Nursing Assistant/CNA) said she was working with E6 the day R1 had a fall. E3 said that she was at break when the incident happened however E6 told her R1 was walking back from an activity and he did not assist her. E3 said R1 is unsteady, has a	A4010		

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A4010	Continued From page 2	A4010		

limp, uses a walker and requires a staff assistance to ambulate and E6 did not assist her and did not pull out the chair for R1 and she ended up falling onto her buttocks. E3 said if E6 would have just walked with her as he was supposed to this could have helped avoid R1 from having a fall.

On 5/23/25 at 11:02 AM, R1 said she did have a fall in the dining room and she needs help walking because her legs hurt.

On 5/23/25 at 12:19 PM, E2 said Service Plans should be updated at six months and annually. E2 verified there was no updated annual service plan for R1 in her medical record.

The facility provided Service Agreement/Service Plan policy last revised on 5/2019 shows that Service Plan should identify the residents need for assistance and those interventions should be implemented. The service plan should reviewed quarterly, after a significant event and reviewed and updated annually.

2.) R2's Service Plan shows he was admitted to the establishment on 2/1/25. R2 uses a wheelchair and requires moderate staff assistance with transfers and cares and is at risk for falls. R2's last service plan intervention notes dated 3/10/25 shows R2 had a fall self transferring and was found lying on the floor. R2 was sent to the Emergency Room per protocol. The Service Plan does not list any intervention was added.

R2's Care Notes show R2 has had falls at the establishment on the following dates: 2/2/25, 2/18/25, 3/10/25, 3/18/25, 5/2/25, 5/5/25, and 5/17/25. There were no Service Plan

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A4010	Continued From page 3 interventions added after those falls. There was a documented note for the fall on 2/2/25 but no intervention added. R3's Service Plan shows she was admitted to the establishment on 3/14/25. R3 uses a walker and is ambulatory. R3's Care Notes show she had a fall on 5/15/25. R3's Service Plan shows no interventions were added after that fall on 5/15/25. On 5/23/25 at 12:19 PM, E2 said Service Plans should be updated after each fall to include the details of the fall and interventions that will be implemented. R2 and R3's Service Plans were reviewed by E2 and this surveyor and E2 verified there were no interventions added after the falls for R2 and R3. E2 said she was the primary person responsible for adding interventions but now nurses should also be adding those after falls. The facility provided Fall Policy last revised on 11/2021 shows that guidelines for evaluating potential causes of a fall should be identified and documented in the clinical record and interventions should be added.	A4010		