STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0047167	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 09/3/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
APOSTOLIC CHRISTIAN RESTMOR	1500 PARKSIDE AVENUE , MORTON, Illinois, 61550

(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) COMPLETION DATE
S0000	Initial Comments Complaint Investigation: 2527513/2585353	S0000		
S9999	Final Observations Statement of Licensure Violation 300.610a) 300.690b) 300.690c) 300.1210b) 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 300.690 Incidents and Accidents b) The facility shall notify the Department of any serious incident or accident. For purposes of this Section, "serious" means any incident or accident that causes physical harm or injury to a resident. c) The facility shall, by fax or phone, notify the Regional Office within 24 hours after each reportable incident or accident. If a reportable incident or accident results in the death of a resident, the facility shall, after contacting local law enforcement pursuant to Section 300.695, notify the Regional Office by phone only. For the purposes of this Section, "notify the Regional Office by phone only" means talk with a Department representative who confirms over the	S9999		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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S9999	Continued from page 1 phone that the requirement to notify the Regional Office by phone has been met. If the facility is unable to contact the Regional Office, it shall notify the Department's toll-free complaint registry hotline. The facility shall send a narrative summary of each reportable accident or incident to the Department within seven days after the occurrence. 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. These requirements were not met as evidenced by: Based on interview and record review the facility failed to notify IDPH (Illinois Department of Public Health) of a serious injury for one of three residents (R1). The facility also failed to ensure a previously implemented fall intervention was in place to reduce the risk of a fall for one of three residents (R1) reviewed for falls in a sample of three. This failure resulted in R1 being transferred to a local emergency room with a left forehead laceration, a left frontal scalp soft tissue hematoma, multiple skin tears and experiencing severe pain. Findings include: The facility's Accident/Incident Policy, dated 3/2025, documents "I. Definition: An incident is any unusual happening involving a resident or visitor. This includes falls with or without injury; injury with or without a fall; behavior which involves danger or injury to self, another resident, employee, or visitor; wandering behavior that puts the resident or other residents in danger; any other happening not considered usual that may create a risk to resident, staff, visitor, or facility. II. Purpose: To assure that all incidents will be appropriately reported and investigated, and action taken to provide maximum safety for residents, visitors, staff, and facility. III. Policy: K. The facility shall notify the Department of any incident or accident that meets the reporting requirements. 1. Notification shall be made by emailing IDPH within 24 hours after each serious	S9999		

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S9999	Continued from page 2 incident or accident; or a narrative summary of each serious accident or incident occurrence shall be mailed to the Department within 7 days after the occurrence." The Accident/Incident Policy, dated 3/2025, documents "I. Definition: An incident is any unusual happening involving a resident or visitor. This includes falls with or without injury; injury with or without a fall.; behavior which involves danger or injury to self, another resident, employee, or visitors; wandering behavior that puts the resident or other residents in danger; any other happening not considered usual that may create a risk to resident, staff, visitor, or facility. L. Every accident/incident shall be investigated to attempt to determine cause. The nurse and the CNA (Certified Nursing Assistant) will complete an investigation for all falls. M. Following the investigation and with a probable cause of the fall is determined, recommendations to prevent a similar fall in the future shall be added to the care plan of the resident." The facility's Fall Prevention Policy, dated 2/2025, documents "Purpose: To provide as safe an environment as possible by taking measures to prevent falls to the extent possible. Policies: C. Every resident shall have safety measures included in the Care Plan from the time of admission. D. The Care Plan safety measures shall be revised as appropriate after a fall occurs and when deemed necessary by nursing. E. After every fall, the cause of the fall shall be determined if possible and measures taken to prevent a similar occurrence in the future." The facility's Silent Bed Alarm Policy, dated 12/2024, documents "I. Purpose: In conjunction with the fall management program, mobility monitors serve to alert the care giver that resident may need assistance. II. Policies: A. A silent bed alarm shall be used at the discretion of the admission nurse, charge nurse, clinical coordinator, Assistant Director of Nursing, or Director of Nursing after assessment of the resident indicates the resident is at risk for falls. B. A silent bed alarm consists of a box that is connected to the resident's call light system and a pressure sensitive pad that is placed on the mattress. G. It is important for the staff on the lanes to be aware of those residents with silent bed alarms and to respond to the call lights promptly. Resident safety is paramount to other duties. H. All silent bed alarms when triggered shall be interpreted as the resident communicating a need. Staff will make attempts to determine the need and provide assistance. I. It shall be the responsibility of each shift to make sure all	S9999		

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S9999	Continued from page 3 silent bed alarms are properly connected and functioning. J. It will be the responsibility of the staff member placing the resident in bed or chair that the silent bed alarm is functioning properly by ensuring the green light is flashing and indicating the alarm is in use. III. Procedures: A. Determine the need for a silent bed alarm through fall risk evaluation. D. Check the proper function of the bed alarm by setting it off and observing that the call light turns on and the CNA's phone rings when the alarm is activated." R1's Face Sheet documents R1 admitted to the facility on 8/16/2023 with the following, but not limited to, diagnoses: Unspecified Dementia (moderate) with Anxiety, Chronic Kidney Disease (Stage 3), COPD (Chronic Obstructive Pulmonary Disease), Generalized Anxiety Disorder, Gastro-esophageal Reflux Disease, Hypertension, Personal History of Transient Ischemic Attack, and Age-Related Osteoporosis without current Pathological Fracture. R1's current Care Plan documents "Problem Start Date: 7/24/2023. Category: Falls. (R1) is at risk for falls related to impaired cognition and being impulsive and thinking that she is capable of doing more herself. Approach Start Date: 7/24/23: 1. Keep call light within reach. Instruct and encourage (R1) to use call light and wait for staff before getting out of bed or off toilet. 2. Keep most frequently used items and assistive devices within reach. 3. Ensure proper footwear is sworn before transfers- non-skin shoes, slippers, socks. 4. Keep room free of clutter. 5. Night light at night. 6. (Staff alerting bed alarm). Monitor for self-transfers and appropriate use of call light. Flowsheet: Fall Prevention." R1's Occurrence Report, dated 10/18/23 and signed by V4/RN (Registered Nurse), documents "Description: (R1) found on the floor. Date/Time of Occurrence: Known, enter date/time: 10/18/23 at 3:30 AM. What was the resident trying to do when the fall occurred? Self-Transfer. Personal Alarm Ordered: yes. Resulted in: Laceration. Skin Tear. Taken to Hospital: Yes. Injury Site: Size: Approximately two-inch laceration at hairline left side of head. Skin tear left shoulder. Color: Bloody. Amount of Bleeding: Large. Body Part: head. Equipment: Bed alarm did not respond to (R1) getting out of bed. Care Plans: Equipment issue referred to Maintenance. New/Additional Fall Prevention Strategies Implemented: Other: Bed alarm replaced. What interventions or changes in routine were implemented by staff? Check bed alarm each shift.	S9999		

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S9999	Continued from page 4 R1's Census documents R1 had a hospital leave on 10/18/23 and didn't return to the facility from the local hospital until 10/23/25. R1's Progress Note, dated 10/18/2023 and signed by V4/RN (Registered Nurse), documents "(V4) went into (R1's) room to check on her. (R1) was found on the floor laying on her back. (R1's) bed alarm was still green and in place on her bed under the fitted sheet, but it had not alarmed. (R1's) head was in the corner of the bedroom next to the bedside table. (R1) had her eyes open and was able to shake her head when (V4) spoke to her. There were no nonverbal signs of pain. There was blood on the floor surrounding (R1's) head. Vital Signs 114/73, pulse 60, respirations 24, oxygen saturation 95% (percent). (R1) was able to follow some directions. Pupils appeared fixed but (R1) did squeeze (V4's) hands upon request and moved lower limbs upon request. Hoyer lift was used to transfer (R1) onto her bed. Warm blanket provided. At 3:50 AM (V4) called (V5/R1's Family Member) and left a message. Vital Signs 142/78, respirations 22, pulse 68, oxygen saturation 93%. (R1) was not responding to requests to follow directions at this time. At 4:00 AM (V4) called (V6/R1's Family Member). (V7/Registered Nurse Supervisor) called (V8/R1's Primary Physician). It was determined that it was in the best interest of (R1) to go to the hospital. (V6) agreed. At 4:18 AM 911 called for transport to the hospital." R1's Nurse Fall Investigation, dated 10/18/23 and signed by V4/RN, documents "What happened: (R1) attempted to self-transfer. Where was the resident: In her room. Severity Level: Major Injury Laceration. Treatment: Sent to Emergency Department, attempted to stop the bleeding. Injury: Laceration to (R1's) head. After reviewing the investigation, what do you think was the cause: (R1) attempted to transfer-unable. Interventions: Replaced bed alarm due to not alarming." R1's Skin Integrity Events, dated 10/18/23 and signed by V4/RN, documents "Description: Laceration left side of head at hairline. Type of Injury: Laceration. Location and Size of Skin Tear/Laceration: Approximately two-inch laceration. Depth of Skin Tear/Laceration: Moderate. Blood Loss- Note Amount and Control: Large Amount. Wound Edges: Irregular. Activity During Skin Tear/Laceration Occurrence: Fall." R1's Skin Integrity Events, dated 10/18/23 and signed by V4/RN documents R1 received a skin tear to the left shoulder related to the unwitnessed fall on 10/18/23. R1's Hospital Records, dated 10/18/23 documents "Chief	S9999		

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S9999	Continued from page 5 Complaint: Fall. Subjective: History of Present Illness: (R1) is a 97-year-old female patient sent to Emergency Room via Emergency Medical Services after unwitnessed fall. (R1) is from (local nursing home). Was found by nursing home staff on the floor next to her bed bleeding from her head with a large skin tear to her left shoulder and right arm…" These same Hospital Records documented, "Chest X-Ray, Bilateral Shoulder X-Rays, Left Elbow X- Rays, and Right-Hand X-Rays. Clinical History: Hypertensive former smoker with low blood pressure, altered mental status, and lacerations of the left shoulder and right arm status post fall. Narrative: Brain and Cervical Spine CT (Computed Tomography) without Intravenous Contrast. Findings: Small left frontal scalp soft tissue hematoma with probable overlying bandaging. Remainder of the scalp soft tissues are unremarkable…" R1's Medical Record did not include evidence of any other fall investigation with a root cause analysis (besides what was listed above) for R1's 10/18/23 fall. R1's Skin Integrity Events-Skin Ulcer Documentation, dated 10/23/23, documents "Description: Left forehead large open wound. Dimension of Ulcer: 4cm (centimeters) x 2.5cm. Depth- Through the top layer of skin. Character of Wound bed: Other: Red, has blood and dried blood superior to open wound. Describe, if necessary: Depended wound is oval in shape, it has large open area. Surrounding tissue: Intact. Describe if necessary: superior skin was elevated appears to be a hematoma. Does the resident complain of pain at the site? Yes-Moans when dressed." R1's Skin Integrity Events, dated 10/23/23, documents "Description: Skin tear left shoulder. Type of Injury: Skin Tear. Location and Size of Skin Tear/Laceration: Left shoulder 4.5cm x 3.5cm. Activity During Skin Tear/Laceration Occurrence: Fall." R1's Skin Integrity Events: dated 10/23/23, documents "Description: Three Skin Tears on Right Forearm. Type of Injury: Skin Tear. Location and Size of Skin Tear/Laceration: Cluster of three skin tears on right forearm. Bottom tear is 1.2cm x 0.4cm next skin tear is 90 degrees on the outer forearm it measures 2.5cm x 0.2cm and the third tear is parallel from dependent wound. This skin tear measures 1.7cm x 0.4cm. These three wounds have scabs on them but were created during the fall. Activity During Skin Tear/Laceration Occurrence: Fall."	S9999		

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S9999	Continued from page 6 On 9/3/25 at 10:42 AM V4/RN stated the morning of 10/18/23 R1 was found on the floor beside her bed with her head in the corner of the room by the bedside table. R1 was lying on her back and had a large laceration observed to her left forehead with a large amount of blood surrounding R1 on the floor. V4 stated, “I also noticed a skin tear to (R1’s) left shoulder. I called (V7/RN Supervisor) to come assist with transferring (R1) back to her bed. I then called (V5/R1’s Family Member) first with no answer so then I called (V6/R1’s Family Member) to let them know about (R1’s) condition. (V7) then called (V8/R1’s Primary Physician) to report (R1’s) condition. It was determined after speaking to (V6) and then (V8) to send R1 out to the hospital due to the head laceration and her being lethargic. I did not get a chance to see if (R1) had any other skin tears at that time or measure any of the areas caused from the fall.” On 9/2/25 at 2:01 PM V3/Director of Nursing verified the Skin tear to R1’s left shoulder, the laceration to R1’s left forehead, and the skin tear to R1’s right arm was sustained from R1’s unwitnessed fall on 10/18/23. V3 stated she is the one responsible to send out a report to the state agency for any falls with major injuries. V3 verified she did not send a report to the state agency for R1’s fall on 10/18/23 that resulted in R1 initially going to the hospital for a head laceration, altered level of consciousness, and multiple skin tears. On 9/3/25 at 11:47AM V7/RN Supervisor stated, “(R1) was on the floor, and was observed to have had quite a bit of bleeding from (R1’s) forehead. The blood had clotted and had stopped bleeding but there was a lot of blood on the floor surrounding (R1’s) head. (R1) was lethargic at the time, kind of sleepy. I remember calling (V8/R1’s Primary Physician) and letting them know what was going on and then getting (R1) sent out to the hospital. That was my focus because (R1) seemed injured.” V7 also stated they (the facility) uses silent bed alarms for high-risk residents who fall to assist with fall prevention. On 9/2/25 at 2:01 PM V3/Director of Nursing stated any resident who is determined a high-risk fall, had fallen out of bed, or attempted to self-transfer would be placed on a silent bed alarm to help prevent falls, then the silent bed alarm would then be placed on the care plan for a fall intervention. V3 verified the only investigations from the fall the facility had was from V4/Registered Nurse who determined the root cause of the fall was the silent bed alarm had not been	S9999		

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S9999	Continued from page 7 functioning properly when R1 got up, so staff were not alerted to get to R1 before R1 had fallen. V3 stated, “The care plan intervention for (R1’s) fall on 10/18/23 was to replace the malfunctioning bed alarm with a new alarm, so I am assuming the bed alarm was not functioning properly as it should. We (the facility) put in place around a year for staff to check the bed alarms each shift to ensure proper functioning, which include staff tapping on the bed alarm first to ensure the bed alarm beeps and is functioning properly prior to placing resident on the bed alarm R1’s Fall Risk Assessment, dated 7/24/25, documents R1 is a high risk for falls. "B"	S9999		