STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145029	A. Building B. Wing	07/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ascension Villa Franciscan	210 North Springfield Avenue Joliet, IL 60435

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. 41639 Based on interview and record review, the facility failed to perform wound treatments, and failed to perform weekly skin assessments as ordered by a physician for a resident (R2) with an arterial heel ulcer. This applies to 1 of 3 residents reviewed for wounds in the sample of 13. The findings include: R2's electronic face sheet printed on 7/31/24 showed R2 had diagnoses including but not limited to non-pressure chronic ulcer of left heel & midfoot, heart failure, local infection of the skin, gout, age-related osteoporosis, and atrial fibrillation. R2's wound physician note dated 10/17/23 showed, Wound has been labeled as a pressure ulcer, however after Doppler study ulcer is more consistent with arterial. R2's physician's orders dated 9/20/23 showed, Weekly skin assessment as per Medicare guidelines-document skin color, turgor, temperature, moisture in nursing note . R2's treatment administration record for November 2023 showed R2 only received 1 out of 4 weekly skin assessment for the entire month. R2's physician's orders dated 10/24/23 showed, Left heel cleanse with wound cleanser, pat dry, apply skin prep to periwound, apply silver alginate, apply gauze, secure with tap daily and as needed. R2's treatment administration record for November 2023 showed R2 did not receive wound care for her left heel on 8 days during the entire month. R2's physician's orders for December 2023 showed, Left heel cleanse with wound cleanser, pat dry, apply hydrogel absorbent sheet, cover with gauze daily and as needed. R2's treatment administration record for December 2023 showed R2 did not receive wound care for her left heel on 7 days during the entire month. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 7/31/24 at 1:10PM, V8 (wound care nurse) stated, All treatments that have been ordered by a resident's physician should be carried out as ordered. I do not do the wound care every day so the floor nurses should be completing it per the treatment record. If there is no documentation that the treatment was completed, then we can only assume it was never done. If we fail to provide treatment, then we can't expect the wounds to get better. On 7/31/24 at 1:50PM, V2 (Director of Nursing) stated, If a treatment record shows a blank area, then I can only assume the treatment was never done. This is a problem because we can't expect to heal a wound if we aren't providing the ordered treatment. The wound care nurse should be following up to ensure that treatments are being completed as ordered but in reality, our nurses know that the treatments need to be completed and they are professionals. The facility was unable to provide a policy regarding treatment of non-pressure wounds.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41639 Based on interview and record review, the facility failed to assess and obtain physician's orders upon identification of an unstageable pressure ulcer for a resident (R4). This applies to 1 of 3 residents reviewed for wounds in the sample of 13. The findings include: R4's electronic face sheet printed on 7/31/24 showed R4 was admitted to the facility on [DATE] with diagnoses including but not limited to left fibula fracture, right calcaneus fracture, generalized anxiety disorder, and insomnia. R4's facility assessment dated [DATE] showed R4 has severe cognitive impairment and no pressure injuries. R4's care plan dated 5/13/24 showed, Risk for impaired skin integrity related to decrease in mobility .daily skin inspection; report any changes in skin or signs of possible skin breakdown or redness. R4's bath and shower documentation form dated 7/19/24 showed, redness and a circle around the buttocks area of the body. No assessment or physician's orders were present for the assessment of R4's redness by a nurse. R4's nursing progress notes dated 7/28/24 showed, Resident voiced to writer that she has a bandage on her backside, and it needs to be changed. Writer looked at treatment orders & noted no order for bandage to sacrum at this time. Writer assessed area, removed old bandage, and noted area to be pink and redness in color, no noted drainage or bleeding, with noted peeling skin around area. Site cleansed with normal saline at this time and wet to dry dressing applied. R4's wound assessment report dated 7/28/24 showed, Unstageable due to suspected deep tissue pressure injury 3x2cm (centimeters). Pending treatment orders. R4's physician's orders dated 7/29/24 showed, Right buttock-cleanse with wound cleanser, pat dry, apply thick layer of zinc once per shift and as needed. On 7/31/24 at 1:50PM, V2 (Director of Nursing) stated, When an aide gives a resident a shower, they report any abnormalities to the nurse so the nurse can assess the area. In (R4's) case, the wound should have been assessed and treatment orders obtained when the wound was identified. The nurses know this process and that they are to notify the wound care team so we can have the wound physician assess the resident and follow them closely to ensure we are doing our best to heal the wound. This wound was obviously identified prior to 7/28/24 as there was a bandage on there but there are no assessments or treatment orders prior to that date. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 7/31/24 at 2:44PM, V9 (wound care physician) stated, (R4) does have a pressure ulcer to her sacral area that was assessed on 7/28/24. From what I understand, a bandage was found on her which prompted a wound assessment and that is when the wound was identified and properly assessed. Whoever found this wound should have performed an assessment, notified the physician for orders, and referred her to the wound care team. It appears that they just put a bandage on and left it which could have potentially caused worsening of the wound due to staff not being aware of the wound and knowing to perform any treatments on it. (R4) could have easily developed this wound overnight due to her immobility and refusal to get out of bed; however, every wound that is identified needs to be properly assessed and treated so we can track it and get it healed quicker. The facility's policy titled, Prevention of Pressure Injuries Protocol dated 1/2018 showed, E. If a new skin alteration is noted, initiate a new skin evaluation record related to the type of alteration in skin .The following information should be recorded in the resident's medical record utilizing community forms: A. The type of assessment conducted B. the date and time and type of skin care provided C. The name and title of the individual who conducted the assessment .E. The condition of the resident's skin .K. Initiation of a (pressure or non-pressure) form related to the type of alteration in skin if new skin alteration noted L. Documentation in medical record addressing physician notification if new skin alteration noted with change of plan of care .

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41639 Based on interview and record review, the facility failed to provide a safe transfer with a mechanical lift for 1 resident (R1). This failure resulted in R1 falling off the side of her bed and obtaining an 8cm (centimeter) laceration to her head requiring 15 staples. This past noncompliance occurred from June 23, 2024, to July 13, 2024. This failure applies to 1 of 3 residents (R1) reviewed for safety and supervision in the sample of 13. The findings include: R1's electronic face sheet printed on 7/31/24 showed R1 has diagnoses including but not limited to lymphedema, repeated falls, hypertension, cognitive impairment, and morbid obesity. R1's facility assessment dated [DATE] showed R1 has severe cognitive impairment and requires substantial/maximum assistance with transfers. R1's care plan dated 12/29/21 showed, Risk for falls and/or fall related injury related to decreased mobility, recent acute medical condition .keep within visibility of staff when up in chair, high risk for falls identifier in place. R1's fall risk assessment dated [DATE] showed R1 is a significant fall risk. R1's local hospital record dated 6/23/24 showed, Patient presents to the emergency department after sustaining a witnessed fall at her nursing home. She is unable to answer questions appropriately due to baseline cognitive deficit. Fall was witnessed and observed to have no loss of consciousness however did sustain a wound to her head which is bleeding .there is an approximate 8cm laceration to the superior portion of the scalp running in a sagittal plane on the right side of the head. Procedure: laceration repair . location: scalp length: 8cm, staples: 15. On 7/30/24 at 10:17AM, R7 (R1's roommate) stated, I heard (R1) fall. The CNA (certified nursing assistant) was putting her in bed, and I think when the CNA backed the lift away, (R1) fell and it sounded like (R1) hit the dresser and then the floor. She was in the corner crying and reached out her hand to me when I came around the curtain to see if she was ok. Her hand was all bloody and she was holding her head, so I knew something bad happened. There was no other CNA in the room except for the one girl. On 7/30/24 at 12:31PM, V4 and V6 (CNAs) stated, When we transfer residents using the sit to stand machine, it is always a 2-person transfer. It has always been that way here as far as we know. (R1) is not safe at all to be sitting on her own on the edge of the bed. That's why you have to have 2 people with the transfer, while 1 person is removing the lift, 1 person can stay with the resident to be sure they don't fall. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	On 7/31/24 at 9:23AM, V5 (CNA) stated, I took (R1) to her room to lay down and when I got her up in the machine and over to the bed, I set her down on the bed and when I was removing the lift, she fell forward. She hit her head on the table by her bed and then hit her head on the floor. I immediately went and got the nurse to assess her. I removed the lift in a manner where the lift was in front of me, and I was behind it and too far from (R1) to even be able to try to save her from falling because the lift was between us. On 7/31/24 at 1:31PM, V10 (R1's nurse practitioner) stated, (R1) is generally weak and not good at following directions due to her severe cognitive impairment. I guess this would have been an avoidable incident and 2 staff members probably should have been with her. On 7/31/24 at 1:50PM, V2 (Director of Nursing) stated, Prior to this incident, my expectation was for 2 staff to perform a sit to stand transfer as this is our policy. (V5) hasn't worked here that long, less than 3 months but she still should know the expectations. This incident could have been avoided if (V5) had another staff person with her who could have ensured (R1) was safe on the bed while (V5) backed the lift away from (R1). The facility's policy titled, Procedure: Lifting Machine, Using a Portable dated 12/2017 showed, The purpose of this procedure is to help lift residents using a manual lifting device. General guidelines: Two nursing associates are required to perform this procedure. Procedure for sit to stand: I. Crank (or raise) the resident up with the lift. Your helper guides the resident by holding the sling. J. Swing the frame of the lift over the bed and slowly lower the resident down onto the bed. K. remove the sling and waist belt from under/behind the resident. L. Reposition the bed covers. Position the resident in a comfortable position that promotes good body alignment .N. Remain with the resident until he or she is comfortable and free from any adverse effects from the transfer .P. Remove the equipment and supplies from the room. Prior to the survey date of 7/30/24, the facility took the following actions to correct the noncompliance on 6/23/24: 1. Resident (R1) was sent to the emergency for evaluation and treatment and has returned to the community. Resident was reassessed by (V7-Licensed Practical Nurse) with no further adverse effects noted at this time. 2. Other residents requiring a sit to stand [lift] have the potential to be affected-these residents were assessed for any falls that occurred in the last 30 days and no further residents were identified. Care plans will be reviewed and updated as needed. 3. QAPI [Quality Assurance and Performance Improvement] meeting held 6/25/24 by the interdisciplinary team and this plan of correction was developed and implemented. 4. Medical director was notified on 6/26/24 and is in agreement with this plan of correction. 5. All direct care licensed nurses and CNA's will be re-educated by the Director of Nursing or designee on or before 7/3/24 on ensuring resident is safe/secure before leaving the room or stepping away from the patient for any reason/not to be left sitting at edge of bed when preparing to use the sit-to-stand. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	6. The policy and procedure: Lifting Machine, Using a Portable has been reviewed by the IDT [Interdisciplinary Team] on 6/25/24 and is deemed appropriate. 7. Under the direction of the QAPI committee, the Director of Nursing or Designee will audit 3 resident transfers with a sit-to-stand each week to ensure resident safety is maintained when preparing to use the lift. Audits will be submitted and reviewed by the QAPI committee for management of ongoing compliance and will continue until otherwise deemed by QAPI. Completion date: 7/3/24 Based on the facility's Staff Education Sign off Sheet, in-services were not completed for all staff until 7/13/24.