

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145029	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/29/2025
NAME OF PROVIDER OR SUPPLIER Ascension Villa Franciscan		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>16746</p> <p>Based on interview and record review the facility failed to send an escort with a resident for an outside imaging appointment.</p> <p>This applies to 1 of 3 residents (R1) reviewed for transportation and escort to medical appointments, in the sample of 3.</p> <p>The findings include:</p> <p>R1 admitted to the facility with diagnoses including but not limited to chronic combined systolic and diastolic heart failure, atherosclerotic heart disease of native coronary artery without angina pectoris, ischemic cardiomyopathy, hypertensive heart disease with heart failure, nonrheumatic mitral (valve) insufficiency, COPD (chronic obstructive pulmonary disease, type 2 diabetes mellitus with foot ulcer, abnormalities of gait and mobility, unsteadiness on feet, and mild cognitive impairment of uncertain or unknown etiology, based on the diagnosis/history report.</p> <p>R1's elopement risk screening and evaluation dated December 13, 2024, showed a score of 8. The same elopement risk screening showed that if the score was 10 or more the resident is at risk.</p> <p>R1's progress notes dated January 16, 2025, at 2:05 PM, created by V4 (RN/Registered Nurse) showed, Patient out to appointment via [ride-sharing service car]. Patient to obtain X-rays with Disc and return to facility.</p> <p>(continued on next page)</p>

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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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On January 22, 2025, at 1:05 PM, V8 (Ward clerk/transportation scheduler) stated that when a resident has a scheduled outside appointment, their respective insurance company are called in advance to schedule for the transportation. According to V8, it is the insurance company who determines what type of transportation is needed by the resident based on the information regarding their mobility. V8 stated for Medicaid residents, the insurance company would ask if the resident is ambulatory and can transfer, if so, the insurance company would use a ride-sharing service car and if the resident used a wheelchair, the insurance company would use either medical-vans or regular ambulance company to transport a resident. V8 further stated that the insurance company would also ask if the resident will be traveling alone or with companion. According to V8, for R1 she called the insurance company for the resident's transportation to and from the appointment for January 16, 2025. Since R1 was ambulatory and could transfer independently, the insurance company had a ride-sharing service car used to transport R1 to his appointment on January 16, 2025. According to V8, she was asked by the insurance company if R1 was traveling alone or with companion and she said, alone. V8 stated that R1,had been sent out to his other appointments before using the ride-sharing service car without an escort and had come back without concerns. No one from nursing told me that he needed someone to go with him to his appointment.</p> <p>On January 22, 2025, at 3:28 PM, V1 (Administrator) stated that on January 16, 2025, R1 went to his imaging appointment using a ride-sharing service car without an escort. V1 stated that even though the imaging office was just around the corner, close to the facility, the facility should have sent a staff with R1. V1 also stated that when she learned that R1 did not come back to the facility in a reasonable time after his appointment on January 16, 2025. All facility staff made sure that residents are accounted on each floor and some staff went out of the facility to look for R1, including at the imaging office and the hospital ER (emergency room) which was next door to the facility. V1 stated that the police, R1's family and physician were notified. V1 stated R1 was found by V2 (Director of Nursing) and V3 (Assistant Director of Nursing) sitting in the hospital ER (next door to the facility).</p> <p>On January 22, 2025, at 4:16 PM, V2 (Director of Nursing) stated that R1 should have been sent out to his appointment on January 16, 2025, with a staff escort due to his changing mental status. According to V2, most of the time, R1 is with it and able to answer questions appropriately, but there are times that he gets confused. V2 stated that she was off on January 16, 2025, when R1 went to his appointment using a ride-sharing service car and she was not aware that the facility did not schedule a staff to accompany the resident. V2 stated that on January 16, 2025, at around 4:50 PM, she received a text message from the facility that R1 did not return to the facility after his imaging appointment. When she (V2) arrived at the facility, the facility staff had already started looking for R1 in the building and surrounding areas and the police had already been notified that R1 was missing. V2 also stated she (V2) and V3 (Assistant Director of Nursing) took their respective cars and went to the hospital ER next to the facility and upon entering the ER, she saw R1 sitting at the waiting area with his cane on his lap. V2 stated that R1 had no visible injury. V2 stated that she asked, R1 where he had been and the resident responded, I do not know why the ambulance brought me here.</p>		