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	07/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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 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. Based on interview and record review, the facility failed to ensure a resident was transferred safely. This failure resulted in R1 sustaining a 10-12-centimeter laceration to left lower leg which required 18 sutures. This applies to one resident (R1) reviewed for injuries in a sample of four.The findings include: Resident Incident Report by V13 (LPN/Licensed Practical Nurse) dated 3/24/25 states R1 sustained a laceration to her left lower leg during transfer from wheelchair to bed. V13's Departmental Note dated 3/24/25 shows R1's laceration was reported by V12 (CNA/Certified Nursing Assistant) who performed R1's transfer. On 7/8/25, at 10:43 AM, V13 said she is unsure of R1's wheelchair footrests were on or off her wheelchair at the time of the incident. On 7/8/25 at 10:32 AM, V12 said that during her shift on 3/24/25, she was transferring R1 from her wheelchair to her bed and R1 sustained a laceration to her left leg. V12 said R1's left leg was closest to her bed and when she pivoted R1 towards the bed, she said ouch. V12 said she then looked down and saw a C or V-shaped cut and more blood than V12 has ever seen. V12 said she didn't know if R1 scraped her leg on the bed or the wheelchair during transfer. V2's (Director of Nursing) Detailed Incident Summary dated 3/29/25 states R1's bedframe was noted with blood on it after the incident. On 7/3/25 at 4:43 PM, V2 said that R1's leg might have rubbed against the bed upon transfer. R1's Emergency Department Physician Report dated 3/24/25 states while facility staff were attempting to transfer R1 from wheelchair into her bed, R1 sustained a large 10 to 12 cm U-shaped skin tear to her left lower leg that required [skin adhesive] and 18 sutures to bolster the wound edges and approximate skin edges. The report also states that it is unknown if she fell or bumped or injured her leg on an object while being moved or transferred. The patient did suffer a large skin tear to her left lower leg. V21's (Wound Doctor) progress note dated 4/30/25 shows that R1 has 1 wound on her left lateral leg measuring 11.5 cm x 5 cm with etiology noted as due to trauma/injury.On 7/9/2025 at 11:45 AM, V1 stated that they do not have specific policies for resident transfers and falls, but they may have policies from the previous facility ownership. The facility only provided a Gait Belt policy (revised 7/26/2024) that showed 2. 1-2 staff might also assist a resident while using a gait belt during transfers and ambulation. The provided policy does not include any other guidance for resident transfers, resident mobility, safety measures, staff body mechanics to support the resident during the transfer, or fall/injury prevention.

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

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	07/11/2025

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0692 Level of Harm - Actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. (continued on next page)

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	07/11/2025

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0692 Level of Harm - Actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to recognize a resident's significant weight loss of 17.8% in one month and implement timely interventions. This failure resulted in R1's continual weight loss of 24% in three months and eventual hospitalization. This applies to one resident (R1) reviewed for decreased oral intake. The findings include:R1's Weights and Vitals Summary show the following weights:1/6/25 165.2 lbs2/6/25 167.2 lbs3/7/25 169.3 lbs4/9/25 139.2 lbs (17.8% loss in 1 month)5/13/25 135.9 lbs6/13/25 128.6 lbs (24% loss in 3 months)7/7/25 113.2 lbsR1's Nutritional Status Notification written by V19 (Registered Dietician) dated 4/14/25 states, please obtain a new weight. April weight indicated a 30 pound weight loss 17.8% suspect may be in error. V19's Dietary Note written 4/14/25 states: Recommendations: Please re-weigh and continue to follow weight trends. Monitor weight, intake, and skin integrity. Goals: Weight maintenance with no significant changes and no signs or symptoms of dehydration. R1's Dietician requested re-weigh was not documented until over 1 month later on 5/13/25 at 135.9 lbs, showing another 3.3 lb loss.After the noted 30 pound one month weight loss on 4/9/25, the facility's next Nutrition Risk Assessment was not documented until 5/7/25 by V20 (Registered Dietician). V20 writes, Reviewed weight history in detail. Weight changes are noted due to errors in scale/recording not nutritional intake.Varied PO intake 25-75% per RN.Nutrition Diagnosis: Inadequate oral intake related to varied PO intake as evidenced by dementia, specific food preferences, 1:1 feeding assistance and encouragement required.Nutrition Interventions:.2. Add Ensure BID. R1's POS (Physician Order Sheet) shows order dated 5/9/25 for Ensure 240mLs twice a day. R1's MAR (Medication Administration Record) shows Ensure was not given to R1 until 5/12/25.On 7/8/25 at 12:47 PM, V16 (RN/Registered Nurse) said she is very familiar with R1 and noticed her decline around March/April 2025 and her 30 pound weight loss in April. On 7/9/25 at 12:37 PM, V16 said if a resident's weight is taken and shows a significant loss, the resident is supposed to be re-weighed right away to make sure the loss is accurate. V16 said after verifying the loss is accurate, the doctor should be called and the dietician notified to see if they want to add any other interventions and those interventions should be put into place immediately. V16 said a delay in adding weight loss interventions is a big harm because the elderly are a fragile population at greater risk for lowered immunity, illness, skin dryness/tears and dehydration due to weight loss. On 7/8/25 at 12:24 PM V15 (Registered Dietician) said if she is suspecting an inaccurate weight, she requests the resident to be re-weighed on the same day, because if the weight loss is accurate, she wants to know immediately so she can add more nutrition interventions for the resident. V15 said based on the weights documented in the system, R1's weights show an accurate significant weight loss. On 7/8/25 at 2:41 PM V15 said after re-weigh was requested on 4/14/25, the next weight was not documented until 5/13/25. V15 said when a re-weigh is requested it should be done that same day to verify. On 7/9/25 at 11:01 AM, V18 (NP/Nurse Practitioner) said if he was notified about R1's significant weight loss he would have ordered supplements for her and he expects the supplements to be started right away. V18 said supplements should have been started for R1 in April when the 30 pound significant weight loss was noted. On 7/9/25 at 2:37 PM, V2 (DON/Director of Nursing) said a delay in implementing weight loss interventions can lead to further weight loss and a decline in the resident's health overall. On 7/9/25 at 2:20 PM V3 (ADON/Assistant Director of Nursing) said a delay in implementing weight loss interventions is harmful because it can lead to more weight loss, muscle wasting, depleted protein stores, electrolyte deficiency, and dehydration. R1's General Progress Note written on 6/16/25 by V16 (RN) states NP was notified of R1's elevated BUN (Blood Urea Nitrogen) along with other recent lab values and resident's poor intake of food. Orders received to send resident to hospital for evaluation and IV fluids.On 7/3/25 at 5:04 PM, V9 (R1's POA/Power of Attorney) said R1 was admitted to the hospital on [DATE] severely dehydrated and with significant weight loss. V9 said she was not made aware of R1's weight loss and was under the impression R1 still weighed in the 160s. V9 said on 5/29/25 at Care Plan meeting, the facility staff told her R1 weighed 170 lbs (pounds), but she since found out that was a wrong weight. V9 said she should have been called when R1's weight went from 169 lbs to 139 lbs in 1 month. V9 said, I should not have been blind sighted by the 113.6 lbs when she was in the hospital.R1's Care Plan did not include nutrition concerns until initiated on 6/20/25 (after she returned from 6/17/25 hospitalization). This Care Plan states resident is at risk for alteration in nutritional status related to. significant weight loss.On 7/8/25 at 4:17 Pm, V1 (Administrator) said the facility does not have a Weight Loss policy, only a policy titled, Weights. The facility's policy titled Weights last revised 8/19/24 states, Policy