

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145563	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/29/2025
NAME OF PROVIDER OR SUPPLIER Ascension Saint Anne Place		STREET ADDRESS, CITY, STATE, ZIP CODE 4405 Highcrest Road Rockford, IL 61107	

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>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to provide incontinence care in a safe manner that prevented a resident from falling out of bed. This applies to 1 of 3 residents (R1) reviewed for falls in the sample of 3.</p> <p>The findings include:</p> <p>R1's Face Sheet showed an admission date of 8/23/23. The face sheet showed that R1 weighed 226 pounds and was 66 inches tall.</p> <p>R1's 4/22/25 Fall Documentation note from 6:42 PM showed, Resident fell out of bed while receiving care from the CNA (Certified Nursing Assistant), landing on her knees. Fall was witnessed without head involvement. ROM (Range of Motion) to all extremities within normal limits. Stated complaint of left knee pain. 2 left knee X-ray ordered stat with confirmation #46925234. Blood pressure 121/77, pulse 73, respirations 18, Temperatures 98.4 (degrees Fahrenheit). Pulse ox 94% on room air. Call placed and message left for Daughter .with no return call back at this time. PRN (as needed) pain medication given as requested and ordered. Will continue to monitor. (Note authored by V4 Licensed Practical Nurse/LPN)</p> <p>R1's 4/23/25 Follow-Up note from 7:05 AM showed R1's knee X-ray indicated no knee fractures. The note showed, .Resident alert c/o (complains of) pain in LLE/knee (left lower extremity) .cold packs applied to left knee during noc (night) shift, BLE (Bilateral/both lower extremities) elevated in bed .</p> <p>R1's 4/23/25 Fall Documentation note from 10:44 AM showed, Resident continues to be on monitoring for a previous fall. Left Knee remains swollen. Stated complaints of left knee pain with PRN pain medications given as requested and ordered with effective results. Remains in bed .</p> <p>R1's 4/24/25 Fall Documentation note from 12:21 PM showed, Resident continues to be on monitoring for a previous fall. Remained in bed today .</p> <p>R1's 4/25/25 Progress note from 12:51 PM showed, (the following note references events which took place on 4/24/25) Resident noted to be lethargic and only able to answer questions with one to two words . answers 'my back' when asked if she is having pain. CNA reported she did not eat her dinner tonight . Provider advised sending resident to the hospital for further evaluation at 20:25 (8:25 PM) .</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>R1's 4/24/25 History and Physical (H&P) from the hospitalist showed, Left hip fracture, acute mechanical fall (recent fall due to external force).</p> <p>R1's 4/24/25 Pelvis X-ray, performed at a local area hospital, showed, Acute mild to moderately displaced closed acute left femoral neck fracture identified (recent hip fracture where the fractured bone is out of alignment) .Diffuse osteopenia (Osteopenia is bone density loss and a precursor to osteoporosis, which is a more advanced bone density loss.)</p> <p>On 4/25/25 at 1:35 PM, V4 LPN stated she has worked at the facility since 6/25/24. V4 stated she knows R1 well, and R1's unit is her typical assignment. V4 stated she was working on 4/22/25 day shift when V5 approached her and informed her that R1 had rolled out of bed while V5 was providing care. V4 stated when she entered the room R1's bed was approximately three feet off the floor, or waist height, and R1 was complaining of left knee pain. V4 said R1 fell and hit her knees on the floor and when she entered the room she was on her knees. V4 said during the assessment process another staff member contacted R1's Nurse Practitioner and obtained an order for a knee X-Ray. V4 said after R1 was assessed on the floor, she was then moved back to bed with a mechanical lift. V4 said V5 had been providing incontinence care for R1 when R1 rolled out of bed and V5 was the only other staff member in the room assisting with care. V4 said, She is incontinent of bowel and bladder. She is dependent upon staff for care. She can't move herself; she is flaccid on the left side. She can't roll side-to-side on her own. If she was on her weak side, her left side, she could not use her right arm to support herself. If she was lying on her side, she would need staff to support her . Two CNAs should be in the room when providing care because she (R1) is not able to roll and she is a larger lady. Also, given that she has limited mobility and strength to support herself, she needed that extra support from another CNA. V4 said R1 continued to have left knee pain on 4/23/25 and 4/24/25; however, that was not atypical for R1.</p> <p>On 4/25/25 at 2:14 PM, V5 CNA stated she has worked as needed for the past two months at the facility. V5 stated she had cared for R1 once or twice prior to the incident on 4/22/25 and caring for R1 is not her usual assignment. V5 said R1 is totally dependent upon staff for her care. V5 stated that she was providing incontinence care independently for R1 on 4/22/25 following a mechanical lift back to bed. V5 said the CNA who assisted with the transfer left, and she noticed R1 had a bowel movement. V5 said, I had her roll to her side, and she kept putting her right leg over her left, and I told her to stop; it was making her lean, and she kind of slid out of bed onto her knees. V5 stated that following R1's incident, the facility implemented two-person incontinence care for her; however, prior to this incident, she had provided care independently for R1. V5 said what determines if a resident requires one or two CNAs for incontinence care is the resident's size and their ability to assist with the care. V5 said, When we have two people, the second person is our supporter, your spotter. Some people (residents) are scared of rolling, and the other person will be supporting the person, like if they had hip surgery or something wrong with their arm, and one person holds the resident, and the other one [provides incontinence care]. One of her (R1's) sides was very stiff; she could move it a little, but she didn't have much motion in it . Having a second person for someone like [R1], someone with weakness on her one side, we probably should have two people for incontinence care to support her when she is on her side because of that weakness she has. If I had a second person with me that day, she probably wouldn't have rolled out of bed because that second person could have held her back and supported her. No one ever told me I needed two people to provide incontinence care for her.</p> <p>(continued on next page)</p>		

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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 4/29/25 at 10:15 AM, V6 Unit Manager/Fall Coordinator stated that some residents need one CNA for incontinence care, and some residents require two CNAs. V6 said that determination is made by the floor nurse when they generate the residents' care plan. V6 said that information then flows to the care guide, which is required to be read by the CNAs every shift. V6 said factors that differentiate a resident requiring one CNA or two CNAs for incontinence care would be the resident's size and their bed mobility. V6 said one aspect of bed mobility is the resident's ability to move side-to-side in bed. V6 said, .So a resident who is either big or has poor bed mobility would need two CNAs. If a resident had a stroke and they were not able to fully support themselves with their good side or keep themselves from rolling out of bed with their good side, they should have two CNAs. The second CNA is safety for the resident and the staff. They (the second CNA) can keep them (resident) up and prevent them from rolling over too far. V6 said, .She (R1) did have weakness to one side of her body. She was a larger lady. She should have had two CNAs in the room with her during incontinence care prior to her fall. It's possible that if the second CNA was in the room, this fall could have been prevented. V6 said R1's care guide, titled bed mobility, is the part of the care guide that informs the CNAs how many staff are required for incontinence care. V6 said that while reviewing R1's care guide at the time of the fall, it showed only one staff member was required for bed mobility. V6 agreed that the level of staff assistance for bed mobility can be different from the level of assistance required for incontinence care. V6 said R1 had chronic pain, and R1 stating left knee pain would not be abnormal.</p> <p>On 4/29/25 at 9:21 AM, V7 CNA stated that she had worked at the facility since July 2024. V7 said she knew R1 well, and R1 was her usual assignment. V7 said R1 requires total care and is incontinent of bowel and bladder. V7 said R1 has left-sided weakness, and she is a bigger lady. V7 said R1 should have two CNAs for incontinence care. V7 said, She can be in a mood; she can fight against you and be unsafe. The second CNA would support her while I provide care. V7 said the second CNA is important for support, given R1's left-sided weakness. V7 said R1's right side (her good side) would not be strong enough to support her and not strong enough to prevent herself from rolling out of bed.</p> <p>On 4/29/25 at 12:44 PM, V8 Medical Director/R1's Physician stated, R1's left femoral neck fracture is the most common type of hip fracture. V8 said the fracture is at the point between the ball of the hip joint and the main portion of the hip bone. V8 said, while reviewing R1's pelvis X-Ray, the acute fracture means the break occurred recently. V8 said, R1 has .osteoporosis and was going to happen one way or the other. The fall contributed to the fracture along with her osteoporosis. Osteoporosis is not listed [as one of R1's diagnoses]. We have to be accurate with what we say so without a bone density test we cannot say it but based on her frailty and the fractures on her spine, it's a clinical judgment.</p> <p>R1's Physician Note (authored by V8 Medical Director) from 4/15/25 showed R1's diagnoses to be stroke with hemiplegia (weakness to one side of the body), heart failure, and atrial fibrillation (irregular, rapid heart rate.) The note showed, Review of systems: .MSK (Musculoskeletal): Denies new muscle pain or new joint swelling. The note continued, Physical Examination: Multiple joints with chronic degenerative changes. (The physician note does not list osteoporosis as a diagnosis or mention it in the note.)</p> <p>R1's 4/26/25 surgery note showed, [R1] is a [AGE] year-old female, presents after fall from nursing facility. The orthopedic surgeon's operative note does not mention osteoporosis.</p> <p>(continued on next page)</p>		

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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>R1's 4/24/25 Nurse Practitioner note showed, Patient is being seen today resting in bed. She is awake, alert, pleasant, and cooperative during the visit .she states she does still have pain in her left knee. Upon examination, she continues with a great deal of swelling to her left knee as well as pain with any palpation (touch). Patient also has pain with assisted ROM (range of motion) including abduction (moving R1's left leg towards R1's midline, towards her right leg), adduction (moving R1's leg away from the midline), flexion (bending her left leg), extension (straightening her left leg), Patient states it 'feels tight and all hurts down there.' (V8's assessment of R1, 9 days prior, showed none of these left leg symptoms.)</p> <p>R1's 2/14/25 Quarterly Minimum Data Set (MDS) showed she was cognitively intact with a brief interview for mental status (BIMS) score of 14 out of 15. The MDS showed R1 was totally dependent on staff for hygiene following a bowel movement, showering, and dressing.</p> <p>On 4/29/25 at 9:45 AM, V2 Director of Nursing stated R1's hip surgery had been done, and she would be returning once the hospital medically cleared her.</p> <p>The National Institutes of Health (NIH) continuing education article (Last updated 5/8/23) showed, Hip fractures are common injuries, especially in the elderly in the emergency setting .Femoral neck fractures are associated with low energy falls in the elderly .risk factors for femoral neck fractures include female gender, decreased mobility, and low bone density.</p> <p>The facility's Clinical Protocol: Urinary Incontinence policy (last approved January 2024) and Clinical Protocol: Urinary Continence and Incontinence-Assessment and Management policy (last approved January 2024) do not discuss assessment of residents for level of staff assistance needed for incontinence care.</p>		