

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145935	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/01/2024
NAME OF PROVIDER OR SUPPLIER Ascension Saint Joseph Village		STREET ADDRESS, CITY, STATE, ZIP CODE 659 East Jefferson Street Freeport, IL 61032	

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 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>22499</p> <p>Based on observation, interview, and record review the facility failed to assess, treat, and document areas of skin damage to a resident's inner thigh and left knee. This applies to 1 of 3 residents (R1) reviewed for skin alterations in a sample of 4.</p> <p>The findings include:</p> <p>On 7/31/24 at 10:30 AM V4 and V5 (Certified Nursing Assistants/CNAs) assisted R1 with perineal care. R1 was very particular with care and resistant to anything suggested to her. V5 stated, (R1) usually allows us to change her one time per shift. R1 stated, That is my choice. Because of this, V4 and V5 used a liner inside of the diaper. R1 stated she was last changed on night shift and her brief and liner were saturated with urine. One bed pad under her was also wet with urine. R1 stated that she does not like to be woken up at 2:00 AM to be changed and she would rather be left alone. R1's wet brief was removed and her skin was washed with skin cleanser and water. There was a foam patch on her coccyx that was swollen with urine, one on her left anterior thigh that also appeared saturated and another on her outer left knee area. V4 and V5 noticed the patches and stated they were going to leave the patches in place as they do not know what is under them and did not want to leave R1's skin exposed. R1 was unaware that the patches were on her skin and states she had no idea how long they have been in place or who put them on.</p> <p>On 7/31/24 11:05 AM V6 (Registered Nurse/RN- Wound Care) stated, R1 gets redness in her folds that come and go and we are using nystatin powder on them with interdry sheets and that seems to work pretty well. She also has the house stock silicone cream that the CNAs can apply anywhere they see an issue. I was not aware that the patches were on so I do not know what is under them either. R1 is very particular and she just came back from the hospital within the past week. Before she went to the hospital her skin was looking pretty good but now she seems to be having the same issues again. She has never had any wounds- just the slits in her skin from the moisture between her folds.</p> <p>At 12:03 PM after assessing R1's skin, V6 (RN- Wound Care) stated, She doesn't have any open areas on her buttocks under the patch. It was just on for protection. Her left knee that patch has a dried up fluid blister under it and she has some MASD (Moisture Associated Skin Damage) on her right interior thigh where the diaper sits and rubs. I put a duoderm (Hydrocolloid dressing) on those.</p> <p>On 7/31/24 st 3:00 PM, V3 (Licensed Practical Nurse/LPN) stated, I did her skin assessment on admission and those bandages were not there. I don't know who put them on her. She did not have any open areas on admission. Just the excoriation to her folds.</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 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>R1's EMR (Electronic Medical Record) shows that R1 was readmitted to the facility from the hospital on 7/28/24. R1's Admission Skin Assessment Sheet dated 7/28/24 shows that R1 has excoriation under her abdominal folds, groin folds, knee folds and buttocks area folds. This form does not show that R1 has any open areas on her inner thigh or left knee.</p> <p>R1's Physician's Order Sheet dated July 2024 does not show any orders for open areas on R1's left inner thigh or left shin/knee.</p> <p>R1's Wound Assessment Report dated 8/1/24 shows that R1 has a new wound to her left inner thigh- front, medial, near peri area that measures 0.8 centimeters (cm) x 2.3 cm x 0.1 cm that was identified on 7/31/24. The cause of this wound is described as moisture.</p> <p>R1's second Wound Assessment Report dated 8/1/24 shows that R1 has a new wound to her left lateral shin, upper that measures 2.8 cm x 1.7 cm x 0.1 cm that was identified on 7/31/24.</p> <p>The facility policy entitled Skin Identification, Evaluation and Monitoring dated 11/2022 states, Licensed nursing associate will evaluate the skin integrity through a physical skin evaluation and use the Braden Skin at Risk tool. Upon admission, weekly for three weeks, quarterly and when a significant change is identified. The nursing assistant will observe the resident's skin when assisting with activities of daily living and report changes to the nurse.</p>		

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<p>F 0689</p> <p>Level of Harm - 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** 22499</p> <p>Based on interview and record review the facility failed to ensure a resident was transferred in a safe manner to prevent injury. This failure resulted in R4 sustaining a fractured femur during a transfer on [DATE]. This applies to 1 of 3 residents (R4) reviewed for falls in a sample of 4.</p> <p>The findings include:</p> <p>R4's Facility Reported Incident dated [DATE] states, Resident, (R4) was lowered to the floor by CNA (Certified Nurses Assistant), (V9), after her knees buckled during a transfer. Resident was sent to (Local Hospital) for further evaluation. Resident returned to the facility with a diagnosis of periprosthetic fracture of the distal femur.</p> <p>R4's Radiographic Image of the knee, right dated [DATE] states, There is a total right knee prosthesis in place. There is a comminuted angulated periprosthetic fracture of the distal femur .</p> <p>On [DATE] at 8:55 AM V9 (CNA) stated, I got her (R4) cleaned up and dressed and we were transferring from the bed to the chair and her legs were giving out so I lowered her to the floor. She sat on her butt on my feet. I was not able to reach the call light so I asked her roommate to push her call light. It took her a minute but then she pushed it. Another CNA came to the door and he saw what happened and went to get the nurse, (V11- Registered Nurse/RN). She (V11) came to the room and assessed her and we got her up. I was able to get my feet out from under her and we lifted her from under her arms and put her in the chair. She was able to kick both of her legs and I heard her say she had some pain but I don't know where. I had never cared for her so I think she was just a 1 assist for transfer. I did not use a gait belt. She was sitting on the edge of the bed and I was standing in front of her. She stood and then she started to shake, almost like she was scared and she became very unsteady. She started to lose her balance so I said it's okay and I lowered her to the floor. I held on to her by her pants and she sat on her butt.</p> <p>On [DATE] at 9:30 AM V10 (Radiologist) stated, It is really hard for me to say what happened. It is all speculation. Per her x-ray (radiography) she had some osteopenia but it is not the most fragile bone. These type of fractures usually happen due to a fall, they do not cause the fall. It looks like there was some twisting motion involved and some energy involved with this fracture pattern. It is a pretty good fracture there.</p> <p>(continued on next page)</p>

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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>On [DATE] at 10:15 AM V12 (RN) stated, The fall happened before my shift started. (R4) is normally one that doesn't complain of pain and doesn't offer any information. She will answer yes and no questions about her pain. My tactic is to ask, is it tolerable or do you need me to help you with your pain. After breakfast the girls (CNA's) told me that (R4) was sitting in the wheelchair with her knees bent but the right knee was not all the way bent. I noticed after they got her in bed that even the slightest movement or palpation she was wincing, but when she was still she was smiling and seemed very comfortable. Her knee looked disjointed. I asked her if she had pain and she told me no. I gave her what I had for pain- Tylenol. I had already called the NP (Nurse Practitioner) and I called the POA (Power of Attorney) to see if they wanted her sent out. It took about 45 minutes for the transport to arrive and her leg was at about 15 degrees. She couldn't straighten it or bend it more than that. It looked a little greenish like maybe it was starting to bruise but nothing major. Over the last ,d+[DATE] weeks she has been better transferring with 2 assist than one. Some days she could stand really well and some days she was more unsteady. At one point she was ambulatory with restorative, so yes she could stand and bear weight. The fall happened about 10 minutes before I arrived and the nurse told me in report that there had been a fall- well kind of a fall because (R4) was lowered to the ground. (V11) had a lot of things going on that night and she was happy she got them all done and then this happened. (V11) asked me if I could call the POA- she had done all the paperwork, so I did.</p> <p>On [DATE] at 1:00 PM V11 (RN) stated, I was at the nurse's station and the call light was going off so the other CNA went to answer it. He came back and told me the resident was on the floor. I told the other nurse and then we went down there and when I walked in the room the resident was on the floor, on her butt with her knees bent and kind of to the side and she was leaning against the (V9's) legs. (V9) told me (R4's) legs gave out when she was trying to transfer her and (V9) lowered (R4) to the floor. I assessed (R4) and did her vital signs and then told her we were going to stand her up and put her in the chair and (R4) said ok. When she got in the chair I asked (R4) to raise her arms and then to move her legs. She was able to move both legs but her kicks were very weak and she was not able to move her legs very far. I asked her if she has pain and she said her right leg hurt but I didn't see any discoloration or deformity in the leg. She was not grimacing and did not show any other outward signs of pain. I went back to the nurse's station and the day shift nurse (V12-RN) was there. I told him what happened and asked him to call the POA. Then I faxed the NP with what had happened. (R4) does not get any medications through the night so I don't interact with her much other than to give (R4) her incentive spirometer. I have cared for her before and never had any problems with her.</p> <p>R4's EMR (Electronic Medical Record) shows that R4 expired in the facility under hospice care on [DATE] at 3:34 AM.</p>		