STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145935	A. Building B. Wing	09/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ascension Saint Joseph Village	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)
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** 39537 Based on observation, interview, and record review the facility failed to safely transfer a resident (R1) for 1 of 4 residents reviewed for safety in the sample of 6. This failure resulted in R1 falling, and hitting her head on the oxygen concentrator. R1's head laceration required 6 staples and 2 sutures for closure of the wound, in the emergency department. The findings include: On 9/10/24 at 10:05 AM, R1 was in wheelchair, being pushed to her room by a family member. There was dried blood and 6 stables on the top of R1's head, in her hairline. There was dried blood and scabbing along the staple line. The surveyor asked R1 if her head was sore and how it happened. R1 said her head hurt real bad when it first happened, but it was starting to get a little better. R1 said she has to take pain medication for the pain some days. R1 said on 8/27/24 she had taken a nap after lunch. R1 said she couldn't remember the CNA's (Certified Nurses Assistant) name. (Through investigation CNA identified as V13). R1 said the CNA came in to help her get up. R1 said she sat up on the side of the bed. R1 said V13 did not use a gait belt. R1 said the wheelchair was positioned to her right, parked near the foot of the bed, facing where she was seated. R1 said she stood with the walker in front of her and all she had to do was pivot to the right and sit down in the wheelchair. R1 said V13 was behind the wheelchair when she was pivoting and was not touching her. R1 said she doesn't really know what happened, but she lost her balance and fell forward. R1 said she didn't pass out or anything like that. R1 said she just fell forward and couldn't stop. R1 said she fell face first and hit her head on the oxygen tank (concentrator). R1 said there was blood everywhere and she was so scared. R1 said she went to the emergency room and they put staples and sutures in her head. R1 said sometimes her legs get weak and she loses her balance. R1 said there's a gait belt right there, pointing to a gait belt hanging on the wall, near her closet. R1 stated, I don't know why they weren't using it. They didn't use it before I fell , but they do now. If they don't use it, then I'm supposed to remind them. R1's Diagnosis/History printed 9/10/24 showed diagnoses to include, but not limited to: chronic kidney disease, morbid obesity, anxiety, insomnia, persistent atrial fibrillation, congestive heart failure, chronic obstructive pulmonary disease, generalized weakness, and other abnormalities of gait and mobility. R1's facility assessment dated [DATE] showed she was cognitively intact; had no behaviors; and required partial to moderate assistance to sit, stand, and transfer from the bed to chair. (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

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 09/13/2024
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)
F 0689 Level of Harm - Actual harm Residents Affected - Few	R1's Care Plan initiated 1/28/24 shoed R1 was at risk for falls due to new surroundings and poor balance. This care plan also showed R1 required limited/extensive assistance of one (staff member) for ADL (Activities of Daily Living) tasks due to weakness and poor balance. The interventions included, but were not limited to: Assist of 1 for all transfers. Use gait belt and walker. R1's Resident Incident Report showed the Fall occurred on 8/27/24 at 4:45 PM. This form showed R1 was transferring from the bed to the wheelchair with the CNA (V13), walker and gait belt. This document showed, (The) patient was in the standing position and turning around to sit in the wheelchair. Patient suddenly leaned forward and fell head first into the oxygen concentrator sitting on the floor next to her bed. CNA unable to stop patient from falling. Laceration noted to frontal area of head/scalp. Excessive bleeding noted. Pressure immediately applied to laceration. Skin tear noted to left forearm - 1.5 cm (centimeters) x 4 cm, skin approximated and dressing applied per protocol . Unable to assess laceration well . transported to ER for evaluation and treatment . R1's Incident Followup Report printed on 9/3/24 showed, .Resident admitted to [local hospital] for (atrial fibrillation with rapid ventricular response). Resident has 2 sutures and 6 staples and plan is to return to facility. On 9/10/24 at 9:22 AM, V7 (LPN - Licensed Practical Nurse) said R1 is alert and oriented. V7 said R1 is aware of what is happening around her and can express her needs. V7 said before R1 fell , therapy had been working with her and she was a super easy 1 assist for transfers. V7 said R1 does get very anxious. V7 said she was working the night R1 fell (8/27/24). V7 said she was not in the room when she fell . V7 said she heard V13 (CNA) yelling out. V7 said she went in the room and R1 was laying on the ground, next to her bed, face first. V7 stated, I think she hit her head on the oxygen concentrator knob. It bled a lot, which added to her anxiety. V7 said R1 just kept begging them to get her up. V7 said R1 was in the hospital a few days and came back with 6 staples and 2 sutures. V7 said R1 also had a half moon shaped skin tear to the left, outer elbow. On 9/10/24 at 10:58 AM, V13 (CNA) said she worked 8/27/24. V13 said she went into R1's room to get her up for dinner. V13 said R1 likes to lay down after each meal. V13 said R1 sat up, she placed the gait belt on her, had the walker in front of R1, and R1 stood up fine and pivoted to the the right. V13 said the wheelchair was behind her legs and all R1 had to do was sit down in the wheelchair. V13 stated, Next thing I know she is falling forward. V13 said she was standing behind R1's wheelchair and did not have a hold of the gait belt when R1 went forward. V13 said R1 hit the oxygen concentrator with her head. V13 said R1 never complained of being dizzy. V13 said there was blood everywhere and she yelled for the nurse. V13 said she couldn't remember exactly what R1 was saying, but remembers her repeating, I'm scared . I fell . V13 said she knows that she's supposed to have her hands on the gait belt at all times to help control the resident's movement, but she was so surprised by the fall. On 9/11/24 at 9:04 AM, V14 (Occupational Therapist/Director of Therapy) said a gait belt should be used any time the staff are transferring or ambulating with a resident. V14 said the gait belt should be properly placed and the staff's hands should remain on the gait belt at all times, during the transfer. V14 stated, You never know what could happen. Their knees may buckle or they lose their balance. V14 said the purpose of the gait belt is to assist the resident with balance and if the resident falls or loses their balance, to help guide the resident slowly to a safe landing. V14 said a resident may still end up on the floor, but the staff guiding them down with the gait belt should decrease the severity of any injuries and possibly prevent an injury from occurring. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	On 9/11/24 at 12:11 PM, V15 (Nurse Practitioner) said she would expect the facility to safely assist residents with transfers. V15 said she was trained to keep your hands on the gait belt throughout the transfer. V15 said she would expect staff to be using the gait belts properly. V15 said R1's scalp injury was directly related to her fall. On 9/12/24 at 12:22 PM, V2 (DON - Director of Nursing) said the staff should being using gait belts any time they transfer or ambulate a resident. V2 said there are gait belts in every resident room. V2 said the purpose of the gait belt is to assist the resident with balance and to guide them to a safe place if they lose their balance. V2 stated the proper use of a gait belt should help reduce the risk of injury. V2 said the staff hands should be on the gait belt at all times, during the transfer. The facility's undated Safety, Body Mechanics, Transfers and Gait Belt Procedures showed, Purpose: .4. To educate staff in appropriate transfer methods to ensure compliance with individual resident care plans. If the techniques demonstrated are followed, residents will be more comfortable and safe, risk to staff injury will be greatly reduced and work will be performed more efficiently. Procedures: A. Safety: 1. Primary concern is the safety and health of the residents. Residents who are properly transferred by staff help prevent common injuries such as fractures, skin tears, bruises, etc. Resident safety can be accomplished by doing the following: .e. Use a gait belt to assure firm grip on the resident. f. Get in a position so that you are in control .

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the appropriate treatment and services to a resident who displays or is diagnosed with dementia. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39537 Based on observation, interview, and record review the facility failed to provide care to a resident with dementia in a manner to prevent escalating agitation for 1 of 3 residents (R4) reviewed for dementia in the sample of 6. The finding include: On 9/11/24 at 10:52 AM, V22 (R4's POA - Power of Attorney for Healthcare) said there was an incident on July 13, 2024 with R4 and four facility staff members in the bathroom. V22 said she hates to use the word abuse, but feels that the facility staff could use more dementia care training. V22 said she was not present during the incident, but was notified by her sister (V21) that was present. V22 said she is an administrator at another facility and CNA (Certified Nursing Assistant), V22 said she is well-versed in Dementia Care and didn't feel like sending four people in to assist with care was appropriate. V22 said R4 is slow to respond, needs time to understand the instructions provided, and gets agitated when too many people are giving instructions and getting loud with him. V22 said it had to be overwhelming and scary for him. V22 said she saw R4 the next day and he had multiple bruises and a bump on the side of his head. V22 said the facility did call, that morning, and report that R4 had a fall. V22 said she thinks the bump on his head was from the incident in the bathroom. V22 said there was another concern with the care provided to R4 on 9/8/24. V22 said she had video footage and felt the CNAs turned R4 roughly and pulled on his sore knee. V22 said R4 has dementia, sometimes gets frustrated with me. V22 said sometimes he needs a break and try to re-approach him later. V22 said that video showed that he wasn't given any time, they just kept providing care. V22 said it was clear to her that the poop had been on R4 for a while and it wouldn't have hurt anything if they gave him a little while to calm down. (continued on next page)

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 9/12/24 at 8:45 AM, V21 (R4's family member) said she was at the facility with her sister on 7/13/24. V21 said it was after supper and R4 was getting tired. V21 said R4 said he had to go to the bathroom, so they notified the staff. V21 said R4 had dementia and it was tough for them to keep him occupied while they waited for facility staff. V21 said at first 2 CNAs showed up and started talking to him. V21 said it took R4 time to process what they were saying. V21 said the CNAs gave R4 instructions and if he didn't comply immediately, then they would repeat it again. They weren't giving him time to comply with their requests. V21 said you could see R4 was getting frustrated. V21 said the 2 CNAs got him into the wheelchair, transferred him into the bathroom, and closed the door. V21 said she couldn't see what was happening in the bathroom. V21 said 2 more CNAs and the nurse (V23 - LPN/Licensed Practical Nurse) came in. V21 said she didn't know the names of the CNAs, but knew the nurse's name (V23). V21 said she just heard a lot of commotion in the bathroom, like they were struggling. V21 said she heard different voices, at louder volumes, giving R4 instructions. V21 said you would hear R4 say, Ow; Don't touch that. That hurts. V21 stated, It had be confusing and overwhelming for him. Now I wish I would have done more, but I didn't know. V21 said at one point the door to the bathroom flew open and a CNA got his wheelchair. V21 said V23 (LPN) went into the bathroom, then came out and was trying to console them. They said it was very upsetting to them because they had never seen R4 act like this. V21 said the staff wasn't yelling at R4, but there voices were definitely louder. V21 stated ,It seemed like they thought if they were louder he would understand them better. You could hear the frustration. I heard someone say, We told you to do this or that. V21 said she heard R4 calling the staff bastards. V21 said one of the CNAs left the room and seemed to be upset. V21 said they got R4 to the bedside, in his wheelchair and he didn't want to transfer to the bed. V21 said the CNAs gave him more instructions, but he said he didn't want to. V21 said they didn't give him time to process or settle down. They just kept giving him instructions. V21 said all 3 CNAs were giving R4 directions. V21 said they were able to get R4 to a sitting position in the bed, but he needed to lay down. V21 said R4 said he didn't want to, then one of the CNAs grabbed his legs and the other used his arms. V21 said they quickly moved him from a seated position to lying in the bed. V21 said R4 yelled, Don't touch it that hurts. V21 said R4's knee was sore from falling at home. V21 said the whole thing was pretty traumatic. V21 said she didn't feel like the staff was being abusive, but stated, It's hard to know what to do. Some staff are so kind and others I just don't understand. On 9/11/24 at 2:52 PM, the surveyor viewed two video clips provided by the complaint. During these clips V5 and V6 (CNAs) are providing incontinence care to R4. The first video starts with R4 lying on his back in bed. V5 and V6 are explaining to R4 that they need to provide care. R4 is asking to be left alone and tensing his body. V5 and V6 abruptly turned R4 onto his right side. V6 was holding his left knee and hip area during the turn. R4 complained of pain and tensed his body, pushing against the CNAs. R4 stated, Cut it out. Gosh darn ya, and can be heard calling the CNAs bastards. R4 is moving his arms around and raised his left hand in the air in V5 and V6's direction. After that, R4 reached in the direction of a crucifix on the wall. R4 is tall and does have a long arm reach. V6 removed the crucifix and placed it on the dresser. R4 is soiled with dry, brown stool from his buttocks to his lower back. The CNAs continued to provide care while R4 continues to yell and try to strike the staff. V5 (CNA) holds R4's hand and knee. R4 moans in pain and asks why she's doing that. V5 explained, Because you're trying to hit me. V5 and V6 continued to provide care to R4 despite his continued agitation. R4's Diagnosis/History printed 9/11/24 showed he had diagnoses to include, but not limited to: Myelodysplastic syndrome, aplastic anemia, hypothyroidism, dementia with agitation, psychosis (not due to a substance or physiological condition), anxiety, osteoarthritis of his left knee, generalized muscle weakness, restlessness/agitation, and violent behavior. (continued on next page)

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R4's facility assessment dated [DATE] showed he has severe cognitive impairment; required partial to moderate staff assistance for sit to lying, lying to sitting, sit to stand, chair to bed transfers, and toilet transfers; was dependent on staff for toilet hygiene; required substantial to maximal assistance for personal hygiene; had an indwelling catheter; and was continent of bowel. R4's Care Plan initiated 7/14/24 showed R4 required limited assistance of one for ADL (Activity of Daily Living) tasks due to weakness and dementia. R4's Cognition Care Plan initiated 7/16/24 showed R4 had impaired thought processes. This document showed approaches to include, but not limited to: Provide consistent caregiver on all shifts; approach resident warmly and positively in a calm manner. Always address resident by name; Calmly talk with resident an offer reassurance prior to initiating cares; and provide instruction to resident using clear voice, simple sentences. R4's Care Plan initiated 7/16/24 showed R4 had verbally abusive behavior, combative, and resistant with care. This document showed approaches to include, but not limited to: approach resident warmly and positively; provide consistency with direct care providers on all shifts; allow resident opportunity to make choices and participate in cares; and do not argue with the resident. R4's Progress Notes did not include an entry on 7/13/24 regarding the incident and behaviors that occurred. R4's Progress Notes did not include an entry on 9/8/24. R4's Psychiatric Provider Note dated 7/31/24 showed R4 was seen for agitation and aggression. This note showed, He recently moved to the facility after family was no longer able to care for him at home due to worsening dementia. Staff report that he has been having episodes of agitation, aggression with physical combativeness, paranoia, wandering and poor safety awareness. Attempts at redirection with verbal cueing or diversionary measures have been mostly ineffective and often times escalates his agitation/aggression. Staff report he has required 1:1 care at times. He is resistant to cares and becomes physically aggressive towards staff . He is variably compliant with medications. Mood has been labile, with frequent anxious outbursts. Quality described as chronic. Moderate to severe. Symptoms are intermittent but escalating. Nothing makes it better . Alert, confused, oriented to person only. Answers some simple questions appropriately. Delusions apparent. No anxiety or agitation during this exam . R4's Psychiatric Provider Note dated 8/28/24 showed R4 was seen for dementia with behavioral disturbance. This document showed, He continues to be resistant to cares and is verbally and physically aggressive towards staff . Mood has been unchanged, labile, with episodes of anxious and agitated outbursts . Assessment: Dementia with behavioral disturbances/psychosis/delusions/agitation/physical aggression-uncontrolled. Change/increase Seroquel to 50 mg BID (twice daily) and monitor as aggressive behaviors pose danger risk to himself and others . (continued on next page)

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 9/11/24 at 2:59 PM, V20 (CNA) said she worked 7/13/24 and was R4's assigned CNA. V20 said the family asked us to get R4 to the bathroom and then lay him down for the night. V20 said every transfer took 10-30 minutes with R4 and usually his daughter would help. V20 said she got V24 (CNA) to help because she was covering the rest of the hall. V20 said R4 was already sitting on the toilet when her and V24 arrived. V20 said R4 would go limp and be dead weight. V20 said there ended up being 4 CNAs in the bathroom and the nurse at one point. V20 said the bathroom was full and there wasn't enough room to move. V20 said they struggled in the bathroom with him for a long time. V20 said we were trying to give him instructions, but he was calling us names, kicking, screaming, and swinging at us. V20 said when they got back to his bedside, R4 stomped his feet down and said he didn't want to do it. V20 said R4 had two daughters in the room and they were upset and crying. V20 said R4 is always agitated. V20 said they didn't stop and give R4 time to calm down. On 9/12/24 at 9:39 AM, V25 (CNA) said R4's daughter came out and told her that R4 had to go the bathroom. V25 said she found a CNA to help her, but she wasn't aware of the name. V25 said 2 more CNAs came in while they were in the bathroom. V25 said R4 got more agitated when there were 4 CNAs in the bathroom. V25 said it was a struggle getting him on the toilet. V25 said R4 was swatting his hands and trying to hit them. V25 said R4 was telling them to let him do it himself. V25 said at some point V23 (LPN) came in and tried to calm him down, but he was still upset. V25 said after R4 was back to the bed, the other 3 CNAs (V20, V24 and V26) said they would handle it. V25 stated, I stepped out because I knew he wanted his space. V25 said she's taken care of R4 before and giving him time and re-approaching him had been successful. V25 stated, It just didn't stop and the other 3 kept going. I don't know what happened when I left the room. V25 said she for sure needed the assistance of 1 CNA, but probably not all 4. V25 said she just completed Dementia Training and learned it's good to step back, talk quieter, approach the resident from the front, and to try not to overwhelm dementia residents. V25 stated, I left because it just seemed like it was too much for him. There were too many people involved and too much going on. On 9/12/24 at 10:07 PM, V23 (LPN) said she was working 7/13/24 and saw a CNA moving quickly in the hallway. V23 said she isn't good with names, but when staff are moving quickly there is likely an issue. V23 said when she went in the room R4's two daughters were in his room, by his bed, and there were four CNAs in the bathroom with R4. V23 said she went in to try to defuse the situation and calm R4 down. V23 said R4 was already on the toilet and the CNAs told her, We got this. V23 said R4 didn't want anyone near him and he was beyond the point of talking reason. V23 said she went to talk to R4's family because they were upset. V23 said she went into R4's room later in the evening, checked his vital signs and did an assessment. V23 said she did not see any injuries. V23 said R4 had a bleeding disease and always seemed to have scattered bruises, but she didn't notice anything new. On 9/12/24 at 10:32 AM, V26 (CNA) said she helped in R4's room and remembers the situation, but not all the specifics. V26 said she was in the room with 2 other CNAs. V26 said she thought R4 had pain to his knee or some kind of injury to his leg that made it difficult for him to transfer. V26 said it took several attempts to transfer resident to chair, toilet, back to the chair, and back to bed. V26 said the nurse (V23) came in to help at some point. V26 said we offered the bedpan, but he refused. V26 stated, Our only option was to do what we could to get him from bed to the wheelchair, to the toilet, then back to the wheelchair and into bed. V26 said R4 bared minimal weight and was fighting against the staff most of the time. V26 said eventually they ended up transferring him with her under his legs and the other two CNAs under his arms. (continued on next page)

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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 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 9/12/24 at 10:51 AM, V5 (CNA) said she provided care to R4 on 9/8/24. V5 said the nurse said R4 would receive his night medications around 7:00 PM and I should try to lay him down around 8:00 PM. V5 said she got V6 (CNA) to help her. V5 said at first she couldn't get him out of the wheelchair. V5 said it took 3 of them (herself, V6 (CNA) and the nurse (V7) to get R4 into the bed. V5 said, I told him what I was doing but he just got agitated. V5 said he had a bowel movement that had soaked through his pants and was on the wheelchair. V5 said when she tried to remove R4's pants, he got agitated. V5 said R4 was cussing and trying to hit them. V5 said at one point R4 did hit V6 (CNA), so I did hold his hands. V5 said he kept fighting us and trying to pinch us, tried to kick us, and was saying threatening things. Later he started reaching for a cross on the wall, so we removed it. We were worried he'd use it as a weapon. He's tall and could have reached it. V5 said they didn't step away and give R4 a break, in an effort to calm him down. V5 said R4 wasn't redirectable and they tried to explain what they were doing. The surveyor asked V5 why R4 was being turned and moved abruptly, without notice. V5 stated, He was just doing difficult [R4] stuff and I was trying to keep him from hurting us. He will ask for help, but when help comes, then he doesn't want it. On 9/12/24 at 11:41 PM, V6 (CNA) said she helped V5 with R4 on 9/8/24. V6 said she stayed over her shift to help V5 with R4. V6 said R4 was covered in poop and it was spilling onto his wheelchair. V5 said we had to clean him up. V6 said R4 was upset about it and the nurse had to help them transfer him to bed, but the nurse told us to clean him up. V6 said R4 was fighting them and calling them bastards. V6 said they had no other option than to change him. V6 said they tried to give him short breaks while they got washcloths, but they didn't stop the care and give him a break and try to re-approach later. V6 said after we were done, R4 said I'll stop fighting and go to bed. V6 said she's had dementia training and some strategies to de-escalate agitation would be to try to explain what is going on; stay calm, don't agitate them more; and to maybe leave them alone for a short time. V6 said it all depends on if the resident is safe. V6 said they did not give R4 a break and try to re-approach. V6 said the nurse told them to provide care. On 9/12/24 at 12:22 PM, V2 (DON/Director of Nurses) said multiple staff attempting to provide care to R4 on 7/13/24 only upset him more. We did provide an in-service on dementia care and discussed not overwhelming dementia care residents and only using the necessary number of staff. V2 said V22 (R4's POA) did make an abuse allegation regarding the care (on 9/8/24) on the morning of 9/10/24. V2 said she watched the video clips and didn't see abusive behavior. V2 said the CNAs needed to provide care and the resident was fighting them. V2 said the CNAs tried to explain what they were doing. V2 said they didn't leave R4 and try to re-approach later. V2 said she did not see the CNAs leave the room. The surveyor asked V2 why the CNAs moved R4 abruptly in the bed. V2 said that she didn't believe they were being forceful, but trying to avoid being injured. (continued on next page)

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 09/13/2024
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)
F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 9/12/24 at 1:12 PM, V1 (Administrator) stated she was aware of there being a toileting issue with R4 on 7/13/24. V1 said V22 (R4's POA) said the staff needed more dementia training. V1 said there shouldn't have been so many staff, in a small area, trying to provide care. V1 said she can see how that would seem overwhelming to a dementia resident. V1 said she asked them, Would you want to be approached like that? [R4] has dementia, how do you think he felt? V1 said the staff was provided Dementia Care Inservcies on 7/24/24 and 9/11/24. V1 said she was notified by V22 (R4's POA) of an allegation of abuse (9/8/24) on the morning of 9/10/24. V1 said she viewed V22's footage and saw the 2 CNAs (V5 and V6) trying to provide incontinence care and R4 fighting them. V1 said she didn't feel that what she saw was abusive, but it was just a short clip (a few minutes of video footage). V1 said she asked V22 to see more footage and she replied, Oh you'll see it. V1 said she interviewed the CNAs and additional education was provided to the staff. V1 said she felt the CNAs were trying to explain and did give a brief break while obtaining washcloths. On 9/11/24 at 12:11 PM, V15 (NP - Nurse Practitioner) said she has seen R4 get agitated and aggressive when the staff tried to redirect him. V15 said she ordered a psychiatric consult and started him on Seroquel (an antipsychotic). V15 said if R4 became agitated and was trying to strike staff during incontinence care, then I would expect the staff to step back and allow R4 some time to calm down. V15 said this situation can be a gray area, because the incontinence care needs to be provided to prevent skin breakdown and risk of infections. On 9/13/24 at 1:47 PM, V27 (Psychiatric NP) said some de-escalating techniques would include verbal cueing, diversions, addressing a physiological need (such as toileting, pain, hunger, etc.) and re-approaching. V27 said every dementia resident has a different experience and it's important to determine what works for that resident. V27 said dementia residents should be approached from the front, given clear instructions, and allowed time to respond. V27 said 4 staff giving R4 instructions, in a small space (the bathroom) would have been overwhelming for him. V27 said R4 may need time to calm down, but staff must also consider his safety. V27 said if R4 didn't want to cooperate at that time, the staff should try to redirect, give the resident some time, and return with a different approach. V27 said she had seen R4 a couple times. V27 said R4 was alert to person only and couldn't appropriately answer questions. V27 was calm during my interactions with him, but the facility records and reports from nursing staff showed that he could be violent, aggressive, and exhibited wandering behaviors. V27 said R4's degree of agitation and aggression were severe and I made additional adjustments to his Seroquel (antipsychotic). V27 said R4 was a new admission to the facility in July. V27 said the first couple weeks can be a very difficult transition for dementia residents. V27 said the loss of independence, familiar surroundings, and frequent family interactions can cause more behaviors during the adjustment phase. V27 said having strange people try to provide private care can cause some fear. V27 said R4 seems to have more agitation with hands on care. The facility did not have a Dementia Care Policy. The facility's Behavioral Assessments, Interventions and Monitoring Policy reviewed 12/2019 showed, . Residents who display, or are diagnosed with, dementia will received appropriate treatment and services to attain or maintain his/her highest practicable, physical, mental, and psychosocial well-being .