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	05/28/2025

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. 39543 Based on interview and record review, the facility failed to identify and report the diversion of a resident's controlled substance. This applies to 1 of 3 residents (R5) reviewed for controlled substances in the sample of 6. The findings include: R5's May 2025 Medication Record (Medication Administration Record, MAR) showed an order for lorazepam (anxiety treatment medication) liquid 2 milligrams per milliliter (ml). The MAR showed 0.25 milliliters should be given under the tongue every four hours as needed for restlessness. R5's Lorazepam Controlled Drug Receipt/Record/Disposition Form (Count Sheet) showed the pharmacy delivered 30.0 ml of lorazepam on 3/28/25. The count sheet showed from 3/28/25 to 5/16/25, 8 doses of lorazepam at 0.25 ml were given. The count sheet showed, on 5/17/25 at 6:00 AM, the count was correct(ed) from 28.0 mls available to 24.0 mls available (a discrepancy of 4 mls). The count showed two nurses signed off on the correction. The count sheet showed, as of 5/27/27, no lorazepam had been dispensed since the correction on 5/17/25. On 5/27/25 at 11:19 AM, V3 Assistant Director of Nursing (ADON) stated that V9 Agency Nurse and V11 Registered Nurse were the nurses who signed the correction. V3 provided V9's phone number. On 5/27/25 at 11:47 AM, V9 was called, and a message was left. V9 was called again at 1:58 PM; no answer. V9 did not return the phone call prior to exiting the survey on 5/28/25 at 2:00 PM. On 5/27/25 at 11:10 AM, V11 stated she was the day nurse on 5/17/25. V11 said during the controlled substance count she noted the lorazepam to be at 24.0 mls. V11 stated that herself and the other nurse signed off on the correction, and she believed V9 would report the discrepancy. V11 did not know what happened to the 4.0 mls of R5's lorazepam. (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:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/27/25 at 1:15 PM, V3 stated nurses should verify the accuracy of the controlled substance counts at the beginning and end of every shift. V3 stated the controlled substances are tightly controlled due to the risk of diversion. V3 stated lorazepam is a controlled substance. V3 stated the medications belong to the residents. V3 stated, while observing R5's lorazepam bottle, there was approximately 24.0 mls in the bottle. V3 stated staff should have reported the missing lorazepam to administration, and to the best of her knowledge, it had not been reported. V3 stated V2 Director of Nursing had resigned and was currently on paid time off until her last day of employment. On 5/27/25 at 1:45 PM, V1 Administrator stated she started working at the facility on 5/12/25. V1 stated she is the abuse coordinator. V1 stated the medications belong to the residents. V1 stated she should have been made aware of the drop in lorazepam, and it should have been reported to the state health department. The facility's Abuse Investigation and Reporting (Last Approved 12/2024) showed, All reports of resident abuse, neglect, exploitation, misappropriation of resident property, mistreatment, electronic mail, social media, videotaping, photographing, and other imaging of residents, and/or injuries of unknown source shall be promptly reported to local, state and federal agencies .

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	145935	A. Building B. Wing	05/28/2025

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident's preferences and goals. 39543 Based on interview and record review, the facility failed to provide wound/skin treatments and failed to perform weekly skin checks. This applies to 4 of 5 (R4, R3, R1, R5) residents reviewed for improper nursing care in the sample of 6. The findings include: 1.) R4's Face Sheet showed she had skin infections, morbid obesity, and congestive heart failure. On 5/27/25 at 12:50 PM, R4 said she may only receive her leg wound care one to two times per week, depending on the staff that are working. R4's 5/26/25 Wound Evaluation and Management Summary report showed she had a non-pressure wound to the left thigh measuring 0.3 centimeters (cm) by 0.7 cm by 0.2 cm deep. The wound report showed a second non-pressure wound to her right knee measuring 4.4 cm by 5.3 cm by 0.7 cm deep. The wound report showed another non-pressure wound to R4's left thigh measuring 0.5 cm by 1.9 cm by 0.1 cm. R4's April 2025 Treatment Record (Treatment Administration Record, TAR) showed weekly skin checks were not documented as being done on 4/6/25, 4/20/25, and 4/27/25. R4's April 2025 TAR showed three separate wound care orders: 1. Left leg to be done two times per week on Monday and Thursday. 2. Right knee wound treatment to be done three times per week. 3. Right lower leg wound to be done three times per week. R4's April 2025 TAR shows these wounds were not documented as being done on 4/21/25 and 4/28/25. R4's May 2025 TAR showed weekly skin checks, as of 5/27/25, were not documented as being done on 5/15/25 and 5/22/25. R4's May 2025 TAR showed two wound care treatments: 1. Left lower thigh wound care to be done twice a week. 2. Right upper leg wound treatment to be done twice a week. R4's May 2025 TAR showed these two treatments were not documented as being done on 5/19/25 and 5/22/25 (days they were ordered to be done). On 5/27/25 at 2:20 PM, V5 Wound Care Nurse stated the purpose of weekly skin checks is to identify skin concerns as early as possible and provide treatment. V5 said the Certified Nursing Assistants do check a resident's skin when providing care; however, nurses have the training to identify problem areas and to identify less obvious skin concerns. V5 said, The purpose of wound care is to promote healing to prevent infection. The only way we know it's done is if it's documented; it should be documented. Same with weekly skin checks, it should be documented if it is done. 2.) R3's 5/26/25 Wound Evaluation and Management Summary showed he had a non-pressure wound to the right upper buttock measuring 0.3 centimeters (cm) by 0.6 cm by 0.2 cm thick. The wound report showed a second wound to the left lower leg measuring 0.6 cm by 0.4 cm by 0.1 cm thick. (continued on next page)

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	145935	A. Building B. Wing	05/28/2025

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 5/27/25 at 9:00 AM, R3 stated he only receives wound care once a week when the wound care physician rounds on him. R3's April 2025 Treatment Record (Treatment Administration Record, TAR) showed weekly skin checks were not documented as being done on 4/7/25, 4/21/25, and 4/28/25. R3's April 2025 TAR showed a single treatment to be applied daily to both of his legs. The TAR showed it was not documented as being done on 4/12/25 and 4/13/25. R3's May 2025 TAR showed a weekly skin check was not documented as being done on 5/12/25. R3's May 2025 TAR showed a wound treatment to his right upper buttock to be done three times a week. The May TAR showed this treatment was not documented as being done on 5/16/25. On 5/27/25 at 2:20 PM, V5 Wound Care Nurse stated the purpose of weekly skin checks is to identify skin concerns as early as possible and provide treatment. V5 said the Certified Nursing Assistants do check a resident's skin when providing care; however, nurses have the training to identify problem areas and to identify less obvious skin concerns. V5 said, The purpose of wound care is to promote healing to prevent infection. The only way we know it's done is if it's documented; it should be documented. Same with weekly skin checks, it should be documented if it is done. 3.) R1's April 2025 Treatment Record (Treatment Administration Record, TAR) showed weekly skin checks were not documented as being done on 4/6/25, 4/13/25, and 4/20/25. R1's April 2025 TAR showed a protective skin preparation was ordered to be applied to his heels twice daily. R1's TAR showed the twice-daily treatments were not documented as being done on 4/3/25-4/6/25, 4/8/25-4/10/25, 4/17/25, 4/19/25, 4/24/25, and 4/30/25 (11 days, 22 applications for each heel). R1's May 2025 TAR showed the topical skin protection for his heels was ordered to be applied twice daily. The May TAR showed it was not documented as being done on 5/3/25, 5/4/25, 5/7/25-5/10/25, 5/12/25, 5/17/25, 5/18/25, and 5/21/25 (10 days or 20 treatments). On 5/27/25 at 2:20 PM, V5 Wound Care Nurse stated the purpose of weekly skin checks is to identify skin concerns as early as possible and provide treatment. V5 said the Certified Nursing Assistants do check a resident's skin when providing care; however, nurses have the training to identify problem areas and to identify less obvious skin concerns. V5 said the skin protectant for resident heels is to prevent skin breakdown. 4.) R5's April 2025 Treatment Record (Treatment Administration Record, TAR) showed a weekly skin check was not documented as being done on 4/28/25. R5's April 2025 TAR showed an order to apply a topical skin protectant to both heels twice daily. The morning treatment was not documented as being done on 4/3/25, 4/5/25, 4/8/25, 4/9/25, 4/17/25, 4/26/25, and 4/27/25. The TAR showed the evening treatments were not documented as being done on 4/4/25, 4/8/25, and 4/26/25. R5's May 2025 TAR showed her weekly skin check was not documented as being done on 5/5/25. (continued on next page)

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	145935	A. Building B. Wing	05/28/2025

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R5's May 2025 TAR showed an order to apply a topical skin protectant to both heels twice daily. The TAR showed the morning treatments were not documented as being done on 5/10/25-5/12/25, and the evening treatments were not documented as being done on 5/8/25-5/10/25, 5/23/25, 5/24/25, and 5/26/25. On 5/27/25 at 2:20 PM, V5 Wound Care Nurse stated the purpose of weekly skin checks is to identify skin concerns as early as possible and provide treatment. V5 said the Certified Nursing Assistants do check a resident's skin when providing care; however, nurses have the training to identify problem areas and to identify less obvious skin concerns. V5 said the skin protectant for resident heels is to prevent skin breakdown. The facility's Skin Identification, Evaluation, and Monitoring policy (Last Approved 5/2025) showed: Weekly: A. Complete a general skin check to evaluate for changes in skin integrity. B. Document in the medical record the finding of the general skin check .

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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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. 39543 Based on observation, interview, and record review, the facility failed to provide treatments for a pressure wound. This applies to 1 of 5 residents (R2) reviewed for wound care in the sample of 6. The findings include: R2's Face Sheet showed she had a stage four pressure injury above her buttocks. On 5/29/25 at 9:25 AM, V5 Wound Care Nurse provided R2's ordered wound care. The wound appeared to be the size as described in R2's 5/26/25 wound note. The wound bed was red and not actively draining. V5 provided wound care and applied a dressing. R2's April 2025 Treatment Record (Treatment Administration Record, TAR) showed an order for twice-daily wound care treatments for her stage four pressure injury. The TAR showed the evening treatments on 4/29/25 and 4/30/25 were not documented as being done. R2's May 2025 TAR showed her pressure injury wound care order carried over from April 2025. The TAR showed her evening 5/10/25 wound care treatment was not documented as being done. On 5/27/25 at 2:20 PM, V5 Wound Care Nurse stated the purpose of wound care treatments was to promote healing and to prevent infection. V5 said if the wound care was not documented, it was not done. V5 said if the residents refuse treatment or they are out of the facility, it would be noted on the TAR. The facility's policy Procedure: Pressure Injury Assessment/Treatment (Last Revised 7/2024) showed: Documentation: The following information should be recorded in the resident's medical record, treatment sheet or designated wound form: A. The date and time the dressing was changed .

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	145935	A. Building B. Wing	05/28/2025

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. 39543 Based on observation, interview, and record review, the facility failed to maintain an accurate disposition of controlled substances, failed to have procedures in place to accurately measure controlled substances, and failed to maintain an accurate log of controlled substances. This applies to 1 of 3 residents (R5) reviewed for controlled substances in the sample of 6. The findings include: 1. R5's May 2025 Medication Record (Medication Administration Record, MAR) showed an order for lorazepam (anxiety treatment medication) liquid 2 milligrams per milliliter (ml). The MAR showed 0.25 milliliters should be given under the tongue every four hours as needed for restlessness. R5's Lorazepam Controlled Drug Receipt/Record/Disposition Form (Count Sheet) showed the pharmacy delivered 30.0 ml of lorazepam on 3/28/25. The count sheet showed from 3/28/25 to 5/16/25, 8 doses of lorazepam at 0.25 ml were given. The count sheet showed, on 5/17/25 at 6:00 AM, the count was correct(ed) from 28.0 mls available to 24.0 mls available (a discrepancy of 4 mls). The count showed two nurses signed off on the correction. On 5/27/25 at 11:19 AM, V3 Assistant Director of Nursing (ADON) stated that V9 Agency Nurse and V11 Registered Nurse were the nurses who signed the correction. V3 provided V9's phone number. On 5/27/25 at 11:47 AM, V9 was called, and a message was left. V9 was called again at 1:58 PM; no answer. V9 did not return the phone call prior to exiting the survey on 5/28/25 at 2:00 PM. On 5/27/25 at 11:10 AM, V11 stated she was the day nurse on 5/17/25. V11 said during the controlled substance count she noted the lorazepam to be at 24.0 mls. V11 stated that herself and the other nurse signed off on the correction, and she believed V9 would report the discrepancy. V11 did not know what happened to the 4.0 mls of R5's lorazepam. On 5/27/25 at 1:15 PM, V3 stated nurses should verify the accuracy of the controlled substance counts at the beginning and end of every shift. V3 stated the controlled substances are tightly controlled due to the risk of diversion. V3 stated lorazepam is a controlled substance. V3 stated V9 should not have signed off on R5's lorazepam count when the 4.0 ml discrepancy was identified. V3 stated V9 should have notified a nurse manager. V3 stated she was not aware of the discrepancy prior to it being brought to her attention on 5/27/25. V3 stated, while viewing R5's lorazepam, her best guess would be the bottle contained 24 mls. V3 stated that V2 Director of Nursing had resigned and V2 was on paid time off during this survey. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. On 5/27/25 at 10:29 AM, V8 Licensed Practical Nurse (LPN) removed R5's liquid lorazepam bottle from the medication refrigerator. The glass bottle had a medicine dropper type cap. The label on the bottle showed it was delivered with 30 mls. The label also had graduation marks starting at 6 mls and ending at 22 mls; the graduations were in 2 ml increments. The level of the lorazepam was above the 22 ml mark. V8 LPN stated she could not determine how much lorazepam was in the bottle without looking at the controlled substance count sheet. V8 was asked to make a rough estimate of the amount of lorazepam in the bottle; V8 stated she was unable. On 5/27/25 at 1:15 PM, V3 Assistant Director of Nursing stated that it is difficult to get an accurate reading in the lorazepam bottle, especially given the bottle graduations stop at 22 mls and the bottle came filled with 30 mls. 3. R5's May 2025 MAR also showed an order for liquid morphine (narcotic pain medication) 20 milligrams per milliliter (ml). The order showed 0.25 milliliters should be given under the tongue every two hours as needed for pain. R5's liquid Morphine Controlled Drug Receipt/Record/Disposition Form (Count Sheet) showed 30 mls were delivered on 3/28/25. The count sheet showed 0.25 mls were dispensed on 3/29/25, 4/17/25, 4/23/25, 5/11/25, 5/20/25, and 5/24/25 at 4:33 PM. Following the 5/24/25 dose at 4:33 PM, there is 0.25 ml documented in the given column. This administration has no date, no time, no amount left, and no nurse signature. On 5/27/25 at 10:29 AM, V8 Licensed Practical Nurse (LPN), R5's nurse, stated she had not dispensed any morphine for R5 on her shift. V8 stated a controlled substance count is done at the beginning and the end of every shift. V8 stated any discrepancies should be taken to administration. On 5/27/25 at 1:15 PM, V3 Assistant Director of Nursing stated that she was not aware of R5's morphine dose that had no date, no time, and no nurse signature. V3 stated this error should have been identified at shift change and either corrected or brought to administration if it could not be corrected. R5's May 2025 Medication Record showed, as of 5/27/25, the last documented dose of morphine was on 5/24/25 at 4:34 PM. The facility's Controlled Substances policy (last approved 12/2024) showed: .I. Associates to count controlled medications at the end of each shift. The associate coming on duty and the associate going off duty are to make count together .the total number of controlled substances are counted and confirmed. Changes that occurred to the count are documented on the shift to shift count sheet .3. They must document and report any discrepancies to the Director of Nursing Services, or designee. a. The associate ending their shift is not to leave until Director of Nursing, or designee, gives approval.