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| 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 06/13/2025 |
| 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.

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| (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>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to ensure a surgical incision was cleansed per physician's order for 1 of 3 residents (R1) reviewed for physician's orders in the sample of 5.</p> <p>The findings include:</p> <p>R1's medical record showed she was admitted to the facility on [DATE] with diagnoses to include fibromyalgia, atherosclerotic heart disease, surgical aftercare following cardiac surgery, myocardial infarction, presence of aortocoronary bypass graft, asthma with acute exacerbation, chronic pain syndrome, muscle wasting, muscle weakness, hypertension, major depressive disorder, obstructive sleep apnea, and hypokalemia. R1's facility assessment dated [DATE] showed she had no cognitive impairments and required partial to moderate assist with most cares.</p> <p>R1's acute care hospital discharge packet dated 5/27/25 showed . Wound Care Orders . Monitor your wounds for signs and symptoms of infection, including redness, swelling, drainage, and odor. If you notice these symptoms call your surgeon's office. Wash incision daily with soap and water. Do not rub the site. Do not use lotions and/or ointments on incision .</p> <p>R1's May and June eTAR (electronic Treatment Administration Record) showed no order entered to wash her incision daily with soap and water. R1's record only included monitoring of the incision site. R1's medical record showed no evidence that her midline incision to her chest was cleaned during her stay from 5/28/25 through 6/9/25.</p> <p>On 6/13/25 at 3:03 PM, V3 (Registered Nurse/Wound Care Nurse) said when R1 was admitted to the facility she was told her incision was to be open to air. V3 said she gets report from the nurse that a resident has a wound upon admission and she will go through the admission paperwork to confirm wound care orders. V3 said she must have overlooked R1's order to wash her incision daily. V3 said there should have been an order entered to clean R1's incision site. V3 said the purpose of washing R1's incision daily would be to keep the area clean and free of germs and prevent infection.</p> <p>On 6/13/25 at 2:51 PM, V2 DON (Director of Nursing) said she was not aware there was an order for wound care. V2 said decisions on how to proceed with orders of that nature go through V3 the wound care nurse. V2 said V3 would typically review the orders and coordinate with either the facility's wound care doctor or nurse practitioner to determine a course of treatment. V2 said it is important to have someone following the wounds because there needs to be orders to ensure monitoring and making sure the wound is healing and having someone to communicate with for orders.</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.

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| 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>The facility's policy and procedure with approval date of 01/2024 showed, Heath Care Provider Orders . Purpose: The purpose of this procedure is to establish uniform guidelines in the receiving and recording of medication orders. Supervision by a Physician; A. A current list of orders must be maintained in the clinical record of each resident . F. Treatment Orders - when recording treatment orders, specify the treatment, frequency, and duration of the treatment .</p> | | |