

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  07/21/2025
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.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.</p> <p>Based on interview and record review the facility failed to ensure residents were treated in a dignified manner for 3 of 3 residents (R1-R3) reviewed for dignity in the sample of 5. The findings include: On 7/21/25 at 9:02 AM, R1 stated, I had a shower last Tuesday (7/15/25). The aide that was with me was on her cell phone the whole time we were in the shower. I don't remember her name. She answered her phone and talked through her earphones. I felt like she wasn't really paying attention to me. I wasn't important. R1's shower records showed R1 did receive a shower on 7/15/25 by V8 Certified Nursing Assistant (CNA). On 7/21/25 at 8:35 AM, R2 stated during her shower on 7/12/25, the CNA that gave her a shower was on her phone. She had her earphones in and her cell phone rang. She answered it (while she was in the shower with R2) and started talking. R2 stated, Why was my bath not more important than her phone call? She has a job because I need help. R2 stated she was unable to remember the name of the CNA that showered her on 7/12/25. R2's shower records showed R2 did receive a shower on 7/12/25 by V9 CNA. On 7/21/25 at 8:45 AM, R3 stated staff are on their personal cell phones all the time. R3 stated she has seen staff on their phone in the hallways and in the main dining room during meals. R3 stated I don't need to much help, but I would not be happy if I needed help, and staff were too busy on their phones. The facility's Resident Council Meeting minutes dated April 2025-June 2025 were reviewed. The minutes showed resident concerns of staff being on their cell phones during work hours was identified during the facility meetings held in April 2025, May 2025, and June 2025. On 7/21/25 at 12:21 PM, V2 Director of Nursing (DON) stated staff are not to be on their cell phones at work and definitely not when providing cares to residents. V2 stated, Staff being on their personal phones at work has been an issue. The facility's Promoting/Maintaining Resident Dignity policy dated 11/2024 showed, It is the policy of this facility to protect and promote resident rights and treat each resident with respect and dignity as well as care for each resident in a manner and in an environment, that maintains or enhances resident's quality of life by recognizing each resident's individuality. All staff members are involved in providing care, directly and indirectly, to residents to promote and maintain resident dignity and respect resident rights. When interacting with the resident, pay attention to the resident as an individual. Encourage conversation that is resident focused and resident centered while providing care or assisting a resident.</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 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide care and assistance to perform activities of daily living for any resident who is unable.</p> <p>Based on interview and record review the facility failed to provide showers to a resident that required staff assistance to shower for 1 of 3 residents (R1) reviewed for activities of daily living (ADLs) in the sample of 5. The findings include: R1's current care plan showed R1 required staff assistance and supervision for showering or bathing. On 7/21/25 at 9:02 AM, R1 stated he's supposed to get at least two showers per week but sometimes he only got one shower per week or none at all. R1's shower records dated 5/1/25-7/21/25 were reviewed. R1's records showed R1 received a shower on 6/27/25. The records showed R1 was not offered and did not receive another shower until 7/11/25 (13 days later). On 7/21/25 at 12:21 PM, V2 Director of Nursing (DON) stated staff are to offer and/or provide a shower or bath to residents twice a week. V2 stated the facility did not have a policy on how often a resident is to be showered/bathed.</p>

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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>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>Based on interview and record review the facility failed to follow up and obtain an ophthalmology appointment for a resident with vision loss for 1 of 3 residents (R1) reviewed for necessary care and services in the sample of 5. The findings include: R1's current care plan showed R1 was visually impaired which required him to wear eyeglasses. A physician order for R1, dated 12/17/24, showed, Ophthalmology consult and treatment as indicated. On 7/21/25 at 9:02 AM, R1 was seated in bed. R1 wore eyeglasses. R1 stated he felt like his vision had gotten worse recently even with wearing his glasses. R1 stated he had an appointment to see an eye doctor but the appointment was canceled. R1 stated he didn't know why the appointment had been canceled. R1 stated he had not been seen by an ophthalmologist and/or had his vision tested in over a year. The facility's resident outside appointment records dated 4/1/25-7/21/25 was reviewed. The records showed R1 had an appointment for an ophthalmology exam on 5/1/25 but the appointment had been canceled due to the ophthalmology office not accepting R1's insurance. The records showed no appointment for R1 to see another ophthalmologist had been scheduled from 5/1/25-7/21/25. On 7/21/25 at 2:17 PM, V2 Director of Nursing (DON) stated she was aware R1's 5/1/25 ophthalmology appointment had been canceled due to that ophthalmology office not accepting R1's insurance. V2 stated, I don't know why an eye appointment hasn't been rescheduled for him. We should have found a doctor that takes his insurance and scheduled an appointment as soon as possible. The facility's Transportation and/or Referrals, Social Services policy dated 12/2019 showed, Social Services associates/a community associate shall coordinate most resident referrals with outside agencies. Social services/community associate will collaborate with the nursing staff or other pertinent disciplines to arrange for services that have been ordered by the physician in a timely manner.</p>		