

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 146056	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/07/2025
NAME OF PROVIDER OR SUPPLIER Ascension Heritage Village		STREET ADDRESS, CITY, STATE, ZIP CODE 901 North Entrance Avenue Kankakee, IL 60901	
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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48526 Based on interview and record review, the facility failed to investigate an allegation of potential abuse and report it the State Agency within the timeframes. This applies to 1 of 1 resident (R1) reviewed for abuse. The findings include: On 12/13/24 at 2:35 PM, the facility submitted State Agency Serious Injury Incident and Communicable Disease Report (Initial Reportable) that documented the following: On 05/20/24, a resident's daughter reported witnessing staff being rough with ADL (Activities of Daily Living) Care, which was noted in our grievance log. The resident has since been discharged from the community. Upon discovery, investigation was started immediately. On 01/02/25 at 1:00 PM the Service and Recovery Form date completed 05/20/24 was reviewed. The form documented [R1's] daughter reports witnessing staff being rough with mother and other patients. Specific examples- dressing, getting out of bed. [R1's] daughter is concerned the rough handling is why mom's wound is bleeding today. More on back: [R1's] daughter reported one staff she is concerned with was [V10] (CNA/Certified Nursing Assistant) but said there have been others. [R1's] daughter also reports some staff have been very gentle. On 01/07/25 at 9:00 AM R1's progress notes were reviewed. The progress notes documented 05/20/24 at 9:55 AM Nurse was informed by staff that blood was leaking from resident's wheelchair. Writer inspected resident's body while sitting in wheelchair, noted copious amounts of dark red blood coming from wound of left hip. Resident placed in bed for wound cleansing. Pressure dressing applied. 05/20/24 at 10:15 AM Wound continues with excessive bleeding, uncontrolled. Another pressure dressing applied. 05/20/24 at 10:18 AM Doctor called, left message with on-call. 05/20/24 at 10:25 AM Doctor returned call with orders to send to ED (Emergency Department) for eval of wounds. 05/20/24 at 10:32 AM (Ambulance) called with ETA (Estimated Time of Arrival) of 20-30 minutes. 05/20/24 at 10:34 AM Daughter called and informed of resident's condition and pending transfer. 05/20/24 at 10:37 AM (Ambulance) arrived with three attendants to transfer resident to (Hospital) ED via stretcher. 05/20/24 at 10:38 AM (Doctor) attending MD (Medical Doctor) given report regarding patient. (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

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R1 was admitted to the facility on [DATE] with multiple diagnoses which included metabolic encephalopathy, dementia, acute embolism, hypertension, and cognitive communication. R1's progress note dated 05/11/24 at 12:30 PM documented Writer received resident from (Hospital) arrived via stretcher accompanied by 2 EMT's (Emergency Medical Technician). Complete body assessment performed. Several bruising on skin related to fall at home. Two wounds present on right hip and left hip covered with (dressing). Lives alone discovered by family lying on floor. Wound left hip debridement in hospital. On 01/07/25 at 10:30 AM a State Agency Serious Injury Incident and Communicable Disease Report (Follow-up Reportable) was reviewed. The Investigation Summary dated 12/17/24 documented the following: The grievance was given immediate, full attention to the bleeding wound and the DON (Director of Nursing) investigated. The same report documented it was determined that the new blood thinners caused spontaneous bleeding from the wound. The following written statements were attached to the report. V2 (DON) wrote I recall the grievance only from re-reading it. I do not recall when it was presented to me. I was off on May 21, 2024. The SSD (Social Services Director) signed it on 05/28/24 so I am assuming that is when I wrote in my part about the wound that was bleeding. I did not respond to the complaint of a CNA being rough. My concerns were focused on the wound. A written statement dated 12/11/24 documented Admin spoke with [former CNA V10] to receive a statement regarding the grievance of rough care back on 05/20/24. [V10] does not recall the incident. The initial and final reportables showed that the facility initiated the rough handling allegation investigation on 12/11/24, seven months after the incident. On 01/02/25 at 9:37 AM V7 (Former Administrator) stated She was on PTO (Paid Time Off) on 05/20/24 when the incident of alleged rough handling had taken place. V7 stated she did not report the incident to State Agency because she was not made aware of the incident until December 2024 when the consultant came to the facility to audit. V7 stated the allegation was not investigated in May. On 01/02/25 at 2:25 PM V2 (DON) stated on 05/20/24 she was not aware of R1 being rough handled. Stated she was only notified by the floor nurse that R1 was having bleeding from her wound, and she was being sent out to the hospital for evaluation. V2 stated she did not speak with R1's daughter that day (05/20/24). V2 stated R1's bleeding was being caused by the wound debridement on its own. The resident was taking Eliquis. After the resident was sent out for evaluation, she was admitted to the hospital but did not return to the facility. I only zoned into the bleeding wound; I did not address the rough handling. V2 stated on 05/28/24 she signed off on the grievance regarding the bleeding wound. I am not sure if the issue of rough handling was told to the abuse coordinator. The abuse coordinator was the administrator. The social services department handles the grievances. When there is an issue, it is their responsibility to notify the proper department manager. That is the normal process. All issues are handled from there. V2 stated V10 was not terminated, she left voluntarily for a position with better pay and closer to home. V2 stated V10 was not sent home pending investigation. I am not aware of an investigation regarding the rough handling. On 01/02/25 at 3:30 PM V1 (Administrator) stated he does not have any knowledge of the alleged rough handling because he was not working at the facility at the time. V1 stated he started as the administrator on 12/18/24. When I started, the investigation was completed. From what I read and heard; I see no evidence of any rough handling occurred. If I got a report of a resident being rough handled, I will follow the company and state guidelines. V1 stated he is the abuse coordinator for the facility. (continued on next page)		

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility's Abuse Investigation and Reporting Policy last approved 12/2024 showed: Policy statement: All reports of resident abuse, neglect, exploitation, misappropriation of resident property, mistreatment, electronic mail, social media, videotaping, photographing, and other imaging of resident, and/or injuries of unknown source ('abuse') shall be promptly reported to local, state and federal agencies (as defined by current regulations) and thoroughly investigated by community management. Conclusions of investigations will also be reported, as defined by the (Facility) Abuse Prevention policy. Policy Interpretation and Implementation: Role of the Administrator or designee: D. The administrator or designee will suspend immediately any employee who has been accused of resident abuse, pending the outcome of the investigation. E. The administrator or designee will monitor for any further potential abuse, neglect, exploitation, or mistreatment is prevented while the investigation is in progress. Reporting: A. All alleged violations involving abuse, neglect, exploitation, or mistreatment, including injuries of an unknown source and misappropriation of property will be reported to the Administrator or designee and to the following other officials or agencies: 1. The State licensing/certification agency responsible for surveying/licensing the community. E. The Administrator or his/her designee will provide the appropriate agencies or individuals listed above with a written report of the findings of the investigation within five (5) working days of the occurrence of the incident .		