STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6008817	A. BUILDING: _____ B. WING _____	C 12/28/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASCENSION SAINT ANNE PLACE	4405 HIGHCREST ROAD ROCKFORD, IL 61107

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S 000	Initial Comments Complaint Investigation 22110117/IL154519	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610 a) 300.690 a) 300.1210 b) 300.1210 c) 300.1210 d)6) Section 300.610 Resident Care Policies a) The facility shall have written policies and procedures governing all services provided by the facility. The written policies and procedures shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee, and representatives of nursing and other services in the facility. The policies shall comply with the Act and this Part. The written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, documented by written, signed and dated minutes of the meeting. Section 300.690 Incidents and Accidents a) The facility shall maintain a file of all written reports of each incident and accident affecting a resident that is not the expected outcome of a resident's condition or disease process. A descriptive summary of each incident or accident affecting a resident shall also be recorded in the progress notes or nurse's notes of that resident.	S9999	Attachment A Statement of Licensure Violations	

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S9999	Continued From page 1 Section 300.1210 General Requirements for Nursing and Personal Care b) The facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive resident care plan. Adequate and properly supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident. c) Each direct care-giving staff shall review and be knowledgeable about his or her residents' respective resident care plan. d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour, seven-day-a-week basis: 6) All necessary precautions shall be taken to assure that the residents' environment remains as free of accident hazards as possible. All nursing personnel shall evaluate residents to see that each resident receives adequate supervision and assistance to prevent accidents. Based on observation, interview, and record review, the facility failed to supervise a resident at risk for falls and failed to follow the facility's policy and procedure for falls for 2 of 3 residents (R1, R3) reviewed for falls in the sample of 3. This failure resulted in R1 sustaining a fracture to his left hip which required a hospitalization and surgical intervention. The findings include: 1. R1's face sheet showed he was admitted to the facility on 9/13/22, with diagnoses to include traumatic subdural hematoma, pneumonia,	S9999		

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chronic kidney disease, spinal stenosis, vascular dementia, and repeated falls.

R1's facility assessment, dated 9/19/22, showed he had mild cognitive impairment and required extensive assistance of staff for transfers, uses a wheelchair, and a walker for ambulation.

R1's medical record showed he was sent to the acute care hospital on 10/14/22, and returned to the facility on 10/20/22.

R1's admission assessment completed by the facility's nurse practitioner at his initial admission to the facility on 9/15/22 showed, "... Chief Complaint: New admit - subdural hematoma... He presented to the [local acute care hospital] on 8/16/22 with fall several days prior.... Assessment... 5. Weakness/Debility.fall risk: facility fall precautions. Physical Therapy and Occupational Therapy, Monitor. 6. Subdural hematoma: acute on chronic, Continue plan of care, monitor, fall precautions..."

The facility's fall log for the previous 3 months showed R1 had an unwitnessed fall on 10/3/22 in his room, an unwitnessed fall on 10/13/22 in his room, and an unwitnessed fall on 10/14/22 in the dining room.

R1's 10/12/22 Physical Therapy Progress Note showed R1 was ambulating 150 feet with a wheeled walker and contact guard assist of one staff. R1's 10/27/22 Physical Therapy Progress note (after his fall with fracture) showed R1 required maximum assist to sit up in bed and was unable to ambulate due to pain and confusion.

R1's facility fall risk assessment, dated 10/3/22, showed R1 was a high risk for falling. R1's record

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contained an "Incident Witness Statement Form", dated 10/13/22 (the day before R1's fall with major injury), which showed an unwitnessed fall, "... 10:30 AM, Left out a patient's room, walking down the hallway unit. Heard patient yelling for help. Went to patient room, saw patient on the floor sitting in upright position... " R1's record contained a nursing note on 10/13/22 showing R1 was found sitting on the floor in his room in from of his wheelchair. There was no fall investigation provided upon request for R1's 10/13/22 fall. R1's fall risk care plan showed problem onset as 9/14/22, and an intervention added on 10/13/22 that showed, "resident should not be left alone in room while in wheelchair..."

On 12/27/22 at 2:30 PM, V12 (R1's Spouse) said she and her son came into the facility on 10/14/22 to visit with R1. V12 said when she entered the facility, she went toward the public bathroom, and her son went to R1's room to take some things into the room. V12 said when she came out of the bathroom, she looked into the dining room as she passed by and saw a man laying on the floor. V12 said she went into the dining room and realized the man was R1 (her husband). V12 said R1 told her (while he was at the hospital) he got up because everyone else in the dining room had left, so he thought he should probably leave too. V12 said she got concerned when the fire department responded to the 911 call and was asking the staff if they saw how R1 fell, and the staff all said no.

R1's Serious Injury Incident Report, dated 10/14/22, showed, "On 10/14/22 around 12:45 PM, after lunch, dietary aide called for help as resident was noted to be on the floor... Resident is alert and verbalized 'I'm just walking to get out of the dining room.'... resident uses a wheelchair

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S9999	Continued From page 4 for mobility and stated he stood up and took a step..." R1's nursing notek dated 10/14/22k showed, "10/14/22 at 12:00 PM - Writer was looking for resident to check his blood sugar before lunch and questioned CNA's (Certified Nursing Assistant) present on the unit. CNA's were unsure of where he went. Went to check residents room and he was not there. Writer requested [Another Nurse] to call the dining room to see if resident was brought down there to eat and CNA [V6] answered and stated he had brought him to the dining room. Writer stated not to leave resident alone. Writer proceeded down to the dining room to check BS (blood sugar). [V6] was sitting near resident and resident had just gotten food delivered to him. Writer told CNA not to leave resident along in the dining room as he is a fall risk. BS was 269. Writer went back to unit to get medications. While down on unit, writer was requested to give another resident pain medication and speak to a family member. While returning to the med cart writer was notified by [RN-Registered Nurse] that resident had fallen in the dining room. While getting the VS (vital signs) to go care for [R1], I see [V6, CNA on B hall]. I asked CNA what happened and he was unsure. CNA stated he was returning another resident to their room and left [R1] in the dining room for a moment. Upon entering the dining room resident was lying on his left side, legs stretched out... While assessing resident for injuries he complained of pain in left hip.... Resident stated he 'was just standing up to walk out of the dining room'...Attempted to roll resident into supine position to be hoyered into his wheelchair. Resident yelled out in pain and could not roll into supine position. Resident stated his pain was in the left knee to ankle at this time and denied hip	S9999		

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S9999	Continued From page 5 pain. Resident's wife walked into the dining room at this time to visit with resident and saw him on the floor. Writer went back to the unit to find resident's son and walked him to the dining room per wife's request. The decision was made by the son and wife to send resident to [Local Acute Care Hospital] for evaluation..." R1's acute care hospital emergency room documentation showed on 10/14/22 R1's xray of his left femur showed, "... Impression: Acute comminuted intertrochanteric fracture left hip..." On 12/27/22 at 12:00 PM, V3 (Certified Occupational Therapy Assistant/Therapy Manager) said R1 worked with both occupational and physical therapy from his admission on 9/14/22, through his discharge to the acute care hospital after his fall on 10/14/22. V3 said R1 returned to the facility on 10/20/22, and was evaluated by the therapy department on 10/21/22. R1 has not shown much progress since his readmission to the facility. On 12/27/22 at 11:48 AM, V5, RN (Registered Nurse), said R1 is alert with confusion. V5 said R1 transfers with a mechanical lift now. V5 said R1 came into the facility after a fall at home, and then went back to the hospital after a fall at the facility. V5 said R1 will try to transfer himself in his room or wherever he might be at the time. On 12/27/22 at 12:50 PM, V8 (Registered Dietitian) said she was in her office located off the main dining room when she heard a dietary aide yell for a CNA. V8 said she came out of the her office and saw R1 on the floor; she started to head down to the north hall to find a nurse. V8 said as she was going down north to find the nurse a CNA was coming from the south wing. V8	S9999		

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S9999	Continued From page 6 said, "The CNAs are supposed to alternate taking residents back to their rooms so there is always a CNA in the dining room but on this day, unfortunately, when I came out of my office there was no CNAs in the dining room, just the dietary aide that found [R1] on the floor was in there." On 12/27/22 at 1:09 PM, V6, CNA, said, "At the time the fall took place [R1] was in the main dining room. I was assigned to supervise the dining room. I was taking another resident back to their room and when I started heading back the nurse flagged me down and said [R1] had a fall..." On 12/27/22 at 3:15 PM, V2, DON (Director of Nursing), said when a fall occurs the nursing staff should be entering a progress note in the resident's record showing a fall occurred and the details of the fall. V2 said she looked through R1's old chart and new chart and can not find documentation regarding his 10/13/22 fall. V2 said she was unable to find a fall investigation for R1's 10/13/22 fall. V2 said R1 had an unwitnessed fall again on 10/14/22 in the dining room. V2 said R1 should not have been left alone in the dining room, but unfortunately, it happened that way. V2 said R1 should have been supervised. On 12/28/22 at 11:03 AM, V13, NP (Nurse Practitioner), said R1 is very confused and he does try to do things on his own, which has resulted in falls since his admission. V13 said she is not sure if R1 is safe to be left alone in his wheelchair, and would have to see his chart to determine that. 2. R3's face sheet showed she was admitted to the facility on 1/27/20, with diagnoses to include Type 2 Diabetes, hypertension, atherosclerotic	S9999		

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disease, hyperlipidemia, osteoarthritis, and chronic kidney disease. R3's facility assessment dated 11/22/22 showed she has mild cognitive impairment and requires limited assist of one staff member for all cares.

The facility's fall log for the previous 3 months showed R3 had fallen on 10/3/22, 10/22/22, 12/3/22, and 12/23/22.

R3's complete medical record was reviewed including agency staff documentation handwritten on paper and showed no progress notes entered in R3's record for there 10/3/22 or her 10/22/22 fall. The fall investigation into R3's 10/3/22 fall was requested and staff were unable to provide the investigation.

On 12/27/22 at 3:15 PM, V2 said she was unable to find documentation of R3's falls on 10/3/22 and 10/22/22. V2 said she would expect to find a progress note in R3's record. V2 went on to say she was unable to locate a fall investigation into R3's fall on 10/3/22. V2 said she would expect a fall investigation to be initiated immediately after the fall because the fall investigation documents are kept at each nursing station.

The facility's policy titled Falls Prevention, with last approved date of 03/2022, showed, "Policy Statement, The intent of this policy is to provide an environment that is free from accident hazards, over which there is control, and provide supervision and intervention to residents to prevent avoidable accidents..." The facility's policy titled Falls with last approved date of 01/2022 showed, "Policy Statement/Overview, The purposes of this procedure is to provide guidelines for evaluation of a resident in the event

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S9999	Continued From page 8 a fall occurred and to assist associates in identification of potential causes of the fall... An incident report shall be completed for resident falls by a Licensed Nurse after the fall occurs." (A)	S9999		