

Illinois State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0041871		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 09/02/2025	
NAME OF PROVIDER OR SUPPLIER ASCENSION SAINT JOSEPH VILLAGE				STREET ADDRESS, CITY, STATE, ZIP CODE 659 EAST JEFFERSON STREET , FREEPORT, Illinois, 61032			
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S0000	Initial Comments		S0000			09/08/2025	
	Investigation of Facility Reported Incident of 7/31/25/2588564						
S9999	Final Observations		S9999			09/08/2025	
	Statement of Licensure Violations:						
	300.1210a)						
	300.1210b)						
	300.1210c)						
	300.1210d)6)						
	Section 300.1210 General Requirements for Nursing and Personal Care						
	a) Comprehensive Resident Care Plan. A facility, with the participation of the resident and the resident's guardian or representative, as applicable, must develop and implement a comprehensive care plan for each resident that includes measurable objectives and timetables to meet the resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment, which allow the resident to attain or maintain the highest practicable level of independent functioning, and provide for discharge planning to the least restrictive setting based on the resident's care needs. The assessment shall be developed with the active participation of the resident and the resident's guardian or representative, as applicable. (Section 3-202.2a of the Act)						
	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						

Office of Primary Care and Health Systems Management

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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S9999	Continued from page 1 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. These regulations were not met as evidenced by: Based on observation, interview and record review the facility failed to ensure a resident (R1), with a urinary catheter in place, was dressed in a manner to prevent a resident injury, failed to ensure facility staff safely managed and positioned a resident's (R2) urinary catheter as the resident ambulated, and failed to ensure a resident (R3) was showered in a manner to prevent a resident fall. This failure resulted in R1 being sent to a local hospital after her skin was lacerated by a plastic clip connected to her urinary catheter as she was being dressed by facility staff. R1 required nine sutures to repair her laceration. These failures apply to 3 of 3 residents (R1, R2, R3) reviewed for resident safety and supervision in the sample of 3. The findings include: 1.R1's hospital discharge records showed R1 was discharged to the facility on 7/28/25 for rehabilitation after being hospitalized for right leg cellulitis, lymphedema, pneumonia, and urinary retention. R1 was discharged with a urinary catheter in place due to her urinary retention. R1 was cognitively intact. A facility incident report dated 7/31/25 showed R1 sustained a laceration to her right lower leg as V4 Certified Nursing Assistant (CNA) was attempting to put pants on R1, V4 "started to pull the catheter system through the resident's leggings and noticed bleeding... The nurse assessed the resident's laceration and applied a dressing. The wound care nurse and the nurse practitioner then evaluated the laceration and the resident was sent to the ER (emergency room) where she received 9 sutures to the anterior right lower leg." R1's hospital discharge instructions dated 7/31/25			S9999			

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S9999	Continued from page 2 showed R1 was discharged, back to the facility, with a diagnosis of a leg laceration that required nine sutures to repair. R1's skin evaluation form dated 7/31/25 showed R1's sutured, right leg laceration measured 4 cm (centimeters) x 1.5 cm. R1's facility records showed R1 was discharged home on 8/18/25. On 9/2/25 at 8:37 AM, R1 was interviewed via telephone about the 7/31/25 incident. R1 stated on 7/31/25, V4 CNA had just finished helping her shower. R1 was seated in a chair in the shower room. V4 CNA was the only staff present at the time of the incident. R1 stated V4 partially put R1's pants on, up to R1's knees. R1 stated as V4 was pulling R1's urinary catheter bag and catheter tubing through the right leg of R1's pants, "that plastic clip (attached to the catheter bag) scraped against my leg and cut me. I told her to stop. She was hurting me. That is when we saw the blood." On 9/2/25 at 9:47 AM, V4 CNA stated, on 7/31/25, she was "trying to pull (R1's) catheter up the right leg of (R1's) pants" when either the ties or the plastic clip (both attached to the urinary catheter system to hang the catheter bag in place) cut R1's right leg. V4 stated she should have put R1's catheter bag and tubing through R1's pant legs first, prior to pulling up R1's pants, to avoid any contact between R1's skin and her catheter. On 9/2/25 at 10:48 AM, V8 Nurse Practitioner (NP) stated on 7/31/25 she was told the plastic clip attached to R1's urinary catheter cut R1's leg as V4 CNA was putting on R1's pants. V8 stated R1's injury could have been prevented had "they put something around the plastic clip to protect (R1's) skin when getting her dressed." V8 stated facility staff could have used a leg bag (urinary catheter drainage bag that attaches directly to a resident's upper leg) to avoid having to pull a catheter bag through R1's pant leg. V8 stated facility staff need to make sure they are protecting a resident's skin especially if the resident's skin is fragile. 2.R2's current care plan showed R2 had diagnoses including encephalopathy, lung cancer, and neuromuscular dysfunction of her bladder. R2's plan showed R2 was at risk for falls as she had a history of falls in the facility. R2 was confused. R2 had a urinary catheter in place to drain her urine. The plan showed facility staff were to ensure R2's catheter bag and tubing were secured in place to avoid any tension on or the pulling of R2's urinary catheter tubing.		S9999				

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S9999	Continued from page 3 On 9/2/25 at 9:20 AM, R2 was seated in a high back wheelchair in the facility's therapy room. R2's urinary drainage bag hung from underneath the seat of R2's wheelchair. R2's urinary catheter tubing was noted sticking out of R2's pants, down by her left ankle. At 9:25 AM, V6 Physical Therapy Assistant (PTA) assisted R2 to a standing position with the use of a walker. R2's urinary catheter bag remained attached to R2's wheelchair located behind R2. R2 took a step and began walking with V6 at her side. As R2 took a step with her left leg, R2's urinary catheter tubing was pulled taut and began pulling R2's left leg slightly back as the catheter tubing and drainage bag remained attached R2's wheelchair. At that time, V7 Occupational Therapy Assistant (OTA) began pushing R2's wheelchair behind R2 as she walked, however, every time R2 took a step with her left leg, R2's catheter tubing was pulled taut as the catheter drainage bag continued to hang off R2's wheelchair, behind R2 as she attempted to ambulate. On 9/2/25 at 12:26 PM, V2 Director of Nursing (DON) stated for a resident that has a urinary catheter in place, the standard urinary drainage bag should be changed to a leg bag drainage system to help promote mobility while in therapy and to help avoid any pulling of a resident's catheter tubing. V2 stated if a leg bag is not used, the resident's catheter bag should be hung off the walker as the resident is walked so there is no pull or tension on a resident's catheter tubing. 3. R3's profile record report printed 9/2/25 showed R3 had diagnoses including repeated falls, hearing loss, dementia, and vision loss. R3's fall risk assessment dated 8/5/25 showed R3 was at risk for falls due to her hearing and vision impairments along with her impaired mobility. R3's Functional Abilities and Goals form dated 8/11/25 showed R3 required substantial assistance from staff when being transferred in the shower or bath. A facility fall incident report dated 8/6/25 showed R3 had an unwitnessed fall in her room as R3 was attempting to reposition herself and fell out of her wheelchair. R3 was not injured. A facility fall incident report dated 8/28/25 showed R3 had a fall in the facility's shower room with V9 Agency CNA present. The report showed R3 lost her balance and was lowered to the shower floor by V9. R3 received no injuries from the fall.		S9999				

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S9999	Continued from page 4 On 9/2/25 at 12:30 PM, this surveyor attempted to interview R3 about her fall on 8/28/25 but was unable to complete the interview due to R3's impaired cognition, vision and hearing. On 9/2/25 at 12:00 PM, V9 Agency CNA stated, on 8/28/25, she took R3 into the shower room via her wheelchair. V9 stated, "I was told by the staff she was independent. She could get up on her own. I knew she was hard of hearing and couldn't see well. I put her in her wheelchair over the by the toilet in the shower room. She tried to scoot out of her wheelchair to stand up. I kept telling her to sit down." V9 stated she was unsure if R3 was able to hear her or see her at that time. V9 stated when she turned to get the shower chair for R3, located by the shower in the shower room, R3 attempted to stand on her own and her legs "buckled". V9 stated she "caught" R3 as she began to fall and lowered her to the ground. On 9/2/25 at 12:26 PM, V2 DON stated staff should check a resident's care plan and/or their transfer status/resident information report that is located behind every resident's door in their rooms to verify a resident's transfer status and exactly how much assistance a resident needs. (B)		S9999				