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 02/21/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	Initial Comments Facility Reported Incident of February 6, 2024 and February 10, 2024 IL170014	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.1210 b) 300.1210 c) 300.1210 d)6) 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.	S9999		

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S9999	Continued From page 1 These requirements are not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure a resident was supervised in preparation for a mechanical lift transfer resulting in a fall with injury, and failed to ensure nonslip material was in place in a wheelchair for 2 of 3 residents (R1, R3) reviewed for safety and supervision in the sample of 5. This failure resulted in R3 receiving an acute subdural hematoma along with 2 lacerations with 8 sutures to the left forehead and R1 receiving 14 sutures to the left forehead. The findings include: 1. R3's 9/23/23 fall risk assessment showed a moderate risk of falls. R3's 2/1/24 facility assessment showed severe cognitive impairment. R3's care plan showed he was alert but with memory deficits and impaired decision making. R3's activity of daily living (ADL) care plan showed he required staff assistance for all ADL's. R3's transfer care plan showed he was unable to transfer independently. R3's fall care plan showed he was severely cognitively impaired, was a high risk for falls, a total mechanical lift, 2 people assist for all transfers, and 2 persons for all care provided. R3's 2/6/24 fall incident report showed resident was found on the floor of his room bleeding. This report was completed by V14, nurse. R3's 2/6/24 local hospital summary showed a	S9999		

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S9999	Continued From page 2	S9999		

93-year-old male with dementia, nonverbal presented due to a fall with head injury. The CT scan results showed an acute subdural hematoma. This note showed eight sutures were used to repair the forehead laceration.

R3's 2/6/24 fax communication form showed a request for orders for a left eye laceration, left forehead abrasions, and right abrasion above the eye.

R3's 2/6/24 wound notes showed a left cheek bruise, a left eye abrasion, a left eye laceration, and a right eye abrasion.

On 2/20/24, R3 was in a common area with numerous other residents. R3's eyes were closed and he did not react to verbal stimuli. There was a television on in the room and no staff were providing uninterrupted supervision.

On 2/20/24 at 11:18 AM, V2, Quality Director, said the root cause analysis of R3's fall showed he fell because his bed was elevated, and the fall mats were not next to the bed.

At 12:21 PM, V16, Certified Nursing Assistant (CNA), said she takes total responsibility for R3's fall from bed on 2/6/24. V16 said she was caring for R3 and readied him to transfer out of bed and left the room for about 10-15 minutes to find help to assist with the transfer. During this time, V16 was alerted that R3 was found on the floor. V16 said she had left R3 alone with the bed in a high position, and no fall mats in place when she exited his room. V16 said she should have never left him alone like that.

At 12:23 PM, V3, Medical Director, said R3's fall should not have occurred. R3 lacked the

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S9999	Continued From page 3	S9999		

understanding of the risk involved in self-transferring and had advanced dementia. V3 said if staff are preparing a resident for a transfer all staff and equipment needed should go into the room. A resident should not be left alone while staff retrieves help or equipment unless the resident was capable of understanding and had a good memory.

A voicemail was left for V14 to contact this surveyor and no return call was received. This report showed R3's bed was in a high position and R3 was on the floor.

2. R1's face sheet showed a 97-year-old female admitted to the facility on 12/8/23.

R1's 12/14/23 facility assessment showed moderate cognitive impairment.

R1's 12/13/23 nursing note showed resident's roommate notified staff R1 had fallen in the room.

R1's 12/13/23 fall incident post actions showed resident to not be in wheelchair in her room by herself.

R1's care plan showed she was alert with short term memory deficits.

R3's 12/14/23 fall interventions showed to place nonslip material in wheelchair and do not leave in an unsupervised area.

R1's 1/30/24 visit note authored by V3 Medical Director showed a history of Alzheimer's Dementia, poor insight and memory and R1 was not a reliable historian.

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V2's investigative notes showed R4 told her R1 was left unsupervised when staff went to get a lift and R1 fell.

R1's 2/6/24 local hospital visit summary showed she was seen for a fall, had complex laceration of the forehead and laceration repair was performed X 2.

R1's care card in her room showed to use nonslip material in the wheelchair and do not leave in an unsupervised area.

R1's 2/6/24 fall incident report showed V12 CNA and V15 nurse were involved.

At 9:16 AM, R1 was in the dining room in a wheelchair at a table. V6, Restorative CNA, brought R1 to her room and assisted by V5, Licensed Practical Nurse. R1 did not have any nonslip material underneath her in her wheelchair. V5 left R1's room. V6 then left R1 unattended in her room.

On 2/20/24 at 9:00 AM, R4 (R1's roommate) said on 2/6/24, R1 was seated on the edge of her bed. A CNA dressed her, left the room for something, and R1 fell.

At 11:18 AM, V2, Quality Director, said the root cause analysis of R1's 2/6/24 fall showed she fell because she attempted to self-transfer. V2 said a grab bar was put on R1's bed on 2/15/24.

At 12:23 PM, V3, Medical Director, said R1 was a high fall risk and if staff intend to transfer her, all staff and equipment should go in so as not to confuse the resident if you leave.

Documents reviewed showed V12 was

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S9999	Continued From page 5 terminated on 2/14/24 due to not following proper procedure resulting in a patient's fall. V2 said R4 is a reliable historian, and V12 told her he left R1's room on 2/6/24 to get help or the lift or something. V2 said R4 told her V12 had left R1 unsupervised on 2/6 when she fell. (A)	S9999		