STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 3000573	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 07/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VILLA FRANCISCAN	210 NORTH SPRINGFIELD AVENUE , JOLIET, Illinois, 60435

(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) COMPLETION DATE
S0000	Initial Comments Complaint Investigations: 2575702/IL195071 2576192/IL195921- 300.690b)c) cited	S0000		
S9999	Final Observations Statement of Licensure Violations 1 of 2: 300.690b) 300.690c) Section 300.690 Incidents and Accidents b) The facility shall notify the Department of any serious incident or accident. For purposes of this Section, "serious" means any incident or accident that causes physical harm or injury to a resident. c) The facility shall, by fax or phone, notify the Regional Office within 24 hours after each reportable incident or accident. If a reportable incident or accident results in the death of a resident, the facility shall, after contacting local law enforcement pursuant to Section 300.695, notify the Regional Office by phone only. For the purposes of this Section, "notify the Regional Office by phone only" means talk with a Department representative who confirms over the phone that the requirement to notify the Regional Office by phone has been met. If the facility is unable to contact the Regional Office, it shall notify the Department's toll-free complaint registry hotline. The facility shall send a narrative summary of each reportable accident or incident to the Department within seven days after the occurrence. These Regulations are not met as evidenced by: Based on interview and record review, the facility failed to notify IDPH (Illinois Department of Public Health) within 24 hours of a serious incident or accident. This applies to one resident (R1) reviewed for reportable incidents.	S9999		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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S9999	Continued from page 1 The findings include: R1's Nursing Note dated 3/24/25 at 3:34 AM states as staff was assisting resident with transfer from wheelchair to bed, she heard the resident say "ouch" and she observed resident with a cut to her left leg. The resident will be transferred to the hospital for further evaluation. R1's "Emergency Department Physician Report" dated 3/24/25 states while facility staff were attempting to transfer R1 from her wheelchair into her bed, R1 sustained a large 10-12 cm (centimeter) U-shaped skin tear to her left lateral lower leg that required 18 sutures and dermabond to bolster the wound edges. On 7/3/25 at 4:43 PM, V2 said she thought she reported R1's 3/24/25 injury to IDPH, but she could not produce any proof incident was reported. On 7/9/25 at 2:37 PM, V2 said R1's laceration incident requiring sutures on 3/24/25 does qualify as an IDPH reportable incident and should have been reported. The facility's policy titled, "Incident Reporting" last revised 1/3/25 states, "Policy Statement: It is the policy of the facility to ensure that all reportable incidents as stipulated in the Section 300.690 state regulations, are reported to the state agency. Procedures: 1. Any serious injury sustained by a resident that is not an expected outcome of the disease process will be reported to IDPH Regional Office…Physical Harm includes…hospital treatment that involves more than diagnostic evaluation… 3. The facility shall, by fax, phone, email, or directly through the IDPH portal notify the Regional Office within 24 hours after each reportable incident or accident…" 300.610a) 300.1210b) 300.1210d)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	S9999		

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S9999	Continued from page 2 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 300.1210 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. 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 are not met as evidenced by: Based on interview and record review, the facility failed to ensure a resident was transferred safely. This failure resulted in R1 sustaining a 10–12-centimeter laceration to left lower leg which required 18 sutures. This applies to one resident (R1) reviewed for injuries in a sample of four. The findings include: “Resident Incident Report” by V13 (LPN/Licensed Practical Nurse) dated 3/24/25 states R1 sustained a laceration to her left lower leg during transfer from wheelchair to bed. V13’s “Departmental Note” dated 3/24/25 shows R1’s laceration was reported by V12 (CNA/Certified Nursing Assistant) who performed R1’s transfer. On 7/8/25, at 10:43 AM, V13 said she is unsure of R1’s wheelchair footrests were on or off her wheelchair at the time of the incident. On 7/8/25 at 10:32 AM, V12 said that during her shift on 3/24/25, she was transferring R1 from her wheelchair to her bed and R1 sustained a laceration to her left	S9999		

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S9999	Continued from page 3 leg. V12 said R1's left leg was closest to her bed and when she pivoted R1 towards the bed, she said "ouch." V12 said she then looked down and saw a C or V-shaped cut and "more blood than V12 has ever seen." V12 said she didn't know if R1 scraped her leg on the bed or the wheelchair during transfer. V2's (Director of Nursing) "Detailed Incident Summary" dated 3/29/25 states R1's bedframe was noted with blood on it after the incident. On 7/3/25 at 4:43 PM, V2 said that R1's leg might have rubbed against the bed upon transfer. R1's "Emergency Department Physician Report" dated 3/24/25 states while facility staff were attempting to transfer R1 from wheelchair into her bed, R1 sustained a "large 10 to 12 cm U-shaped skin tear to her left lower leg" that required [skin adhesive] and 18 sutures to bolster the wound edges and approximate skin edges. The report also states that it is "unknown if she fell or bumped or injured her leg on an object while being moved or transferred. The patient did suffer a large skin tear to her left lower leg. " V21's (Wound Doctor) progress note dated 4/30/25 shows that R1 has 1 wound on her left lateral leg measuring 11.5 cm x 5 cm with etiology noted as due to "trauma/injury." On 7/9/2025 at 11:45 AM, V1 stated that they do not have specific policies for resident transfers and falls, but they may have policies from the previous facility ownership. The facility only provided a Gait Belt policy (revised 7/26/2024) that showed "2. 1-2 staff might also assist a resident while using a gait belt during transfers and ambulation." The provided policy does not include any other guidance for resident transfers, resident mobility, safety measures, staff body mechanics to support the resident during the transfer, or fall/injury prevention. (B) Statement of Licensure Findings 2 of 2: 300.610a) 300.1010h) 300.1210b) 300.1210d)3) 300.1220b)3) Section 300.610 Resident Care Policies	S9999		

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S9999	Continued from page 4 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 300.1010 Medical Care Policies h) The facility shall notify the resident's physician of any accident, injury, or significant change in a resident's condition that threatens the health, safety or welfare of a resident, including, but not limited to, the presence of incipient or manifest decubitus ulcers or a weight loss or gain of five percent or more within a period of 30 days. The facility shall obtain and record the physician's plan of care for the care or treatment of such accident, injury or change in condition at the time of notification. 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. 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: 3) Objective observations of changes in a resident's condition, including mental and emotional changes, as a means for analyzing and determining care required and the need for further medical evaluation and treatment shall be made by nursing staff and recorded in the resident's medical record. Section 300.1220 Supervision of Nursing Services b) The DON shall supervise and oversee the nursing services of the facility, including:	S9999		

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S9999	Continued from page 5 3) Developing an up-to-date resident care plan for each resident based on the resident's comprehensive assessment, individual needs and goals to be accomplished, physician's orders, and personal care and nursing needs. Personnel, representing other services such as nursing, activities, dietary, and such other modalities as are ordered by the physician, shall be involved in the preparation of the resident care plan. The plan shall be in writing and shall be reviewed and modified in keeping with the care needed as indicated by the resident's condition. The plan shall be reviewed at least every three months. These Regulations are not met as evidenced by: Based on interview and record review, the facility failed to recognize a resident's significant weight loss of 17.8% in one month and implement timely interventions. This failure resulted in R1's continual weight loss of 24% in three months and eventual hospitalization. This applies to one resident (R1) reviewed for decreased oral intake. The findings include: R1's Weights and Vitals Summary show the following weights: 1/6/25 165.2 lbs 2/6/25 167.2 lbs 3/7/25 169.3 lbs 4/9/25 139.2 lbs (17.8% loss in 1 month) 5/13/25 135.9 lbs 6/13/25 128.6 lbs (24% loss in 3 months) 7/7/25 113.2 lbs R1's "Nutritional Status Notification" written by V19 (Registered Dietician) dated 4/14/25 states, "please obtain a new weight. April weight indicated a 30 pound weight loss 17.8% suspect may be in error." V19's Dietary Note written 4/14/25 states: Recommendations: Please re-weigh and continue to follow weight trends. Monitor weight, intake, and skin integrity. Goals: Weight maintenance with no significant changes and no signs or symptoms of dehydration. R1's Dietician requested re-weigh was not documented until over 1 month later on 5/13/25 at 135.9 lbs, showing another	S9999		

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S9999	Continued from page 6 3.3 lb loss. After the noted 30 pound one month weight loss on 4/9/25, the facility's next "Nutrition Risk Assessment" was not documented until 5/7/25 by V20 (Registered Dietician). V20 writes, "Reviewed weight history in detail. Weight changes are noted due to errors in scale/recording not nutritional intake…Varied PO intake 25-75% per RN…Nutrition Diagnosis: Inadequate oral intake related to varied PO intake as evidenced by dementia, specific food preferences, 1:1 feeding assistance and encouragement required…Nutrition Interventions:…2. Add Ensure BID…" R1's POS (Physician Order Sheet) shows order dated 5/9/25 for Ensure 240mLs twice a day. R1's MAR (Medication Administration Record) shows Ensure was not given to R1 until 5/12/25. On 7/8/25 at 12:47 PM, V16 (RN/Registered Nurse) said she is very familiar with R1 and noticed her decline around March/April 2025 and her 30 pound weight loss in April. On 7/9/25 at 12:37 PM, V16 said if a resident's weight is taken and shows a significant loss, the resident is supposed to be re-weighed right away to make sure the loss is accurate. V16 said after verifying the loss is accurate, the doctor should be called and the dietician notified to see if they want to add any other interventions and those interventions should be put into place immediately. V16 said a delay in adding weight loss interventions is a "big harm" because the elderly are a fragile population at greater risk for lowered immunity, illness, skin dryness/tears and dehydration due to weight loss. On 7/8/25 at 12:24 PM V15 (Registered Dietician) said if she is suspecting an inaccurate weight, she requests the resident to be re-weighed on the same day, because if the weight loss is accurate, she wants to know immediately so she can add more nutrition interventions for the resident. V15 said based on the weights documented in the system, R1's weights show an accurate significant weight loss. On 7/8/25 at 2:41 PM V15 said after re-weigh was requested on 4/14/25, the next weight was not documented until 5/13/25. V15 said when a re-weigh is requested it should be done that same day to verify. On 7/9/25 at 11:01 AM, V18 (NP/Nurse Practitioner) said if he was notified about R1's significant weight loss he would have ordered supplements for her and he expects the supplements to be started right away. V18 said supplements should have been started for R1 in April when the 30 pound significant weight loss was noted. On 7/9/25 at 2:37 PM, V2 (DON/Director of Nursing) said a delay in implementing weight loss interventions can lead to further weight loss and a decline in the	S9999		

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S9999	Continued from page 7 resident's health overall. On 7/9/25 at 2:20 PM V3 (ADON/Assistant Director of Nursing) said a delay in implementing weight loss interventions is harmful because it can lead to more weight loss, muscle wasting, depleted protein stores, electrolyte deficiency, and dehydration. R1's General Progress Note written on 6/16/25 by V16 (RN) states NP was notified of R1's elevated BUN (Blood Urea Nitrogen) along with other recent lab values and resident's poor intake of food. Orders received to send resident to hospital for evaluation and IV fluids. On 7/3/25 at 5:04 PM, V9 (R1's POA/Power of Attorney) said R1 was admitted to the hospital on 6/17/25 severely dehydrated and with significant weight loss. V9 said she was not made aware of R1's weight loss and was under the impression R1 still weighed in the 160s. V9 said on 5/29/25 at Care Plan meeting, the facility staff told her R1 weighed 170 lbs (pounds), but she since found out that was a wrong weight. V9 said she should have been called when R1's weight went from 169 lbs to 139 lbs in 1 month. V9 said, "I should not have been blind sighted by the 113.6 lbs when she was in the hospital." R1's Care Plan did not include nutrition concerns until initiated on 6/20/25 (after she returned from 6/17/25 hospitalization). This Care Plan states resident is at risk for alteration in nutritional status related to…significant weight loss. On 7/8/25 at 4:17 Pm, V1 (Administrator) said the facility does not have a Weight Loss policy, only a policy titled, "Weights". The facility's policy titled "Weights" last revised 8/19/24 states, "Policy Statement: It is the facility's policy to obtain resident's monthly weight unless ordered differently…Procedures:…3. The significant weight changes (monthly (5%), quarterly (7.5%), and every 6 months (10%)) will be assessed and addressed by the IDT which includes but not limited to the Dietician, Physician, Medical Specialist, Speech Therapist, Nutritionist, and Nurses." (B)	S9999		