STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: **0041731**	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED **07/08/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASCENSION SAINT ANNE PLACE	**4405 HIGHCREST ROAD , ROCKFORD, Illinois, 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) COMPLETION DATE
S0000	Initial Comments Facility Report Incident of 6/20/25/IL#195523	S0000		
S9999	Final Observations Statement of Licensure Violatonss 300.610a) 300.1010h) 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 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	S9999		

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

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S9999	Continued from page 1 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: 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 requirements were not met as evidence by: Based on observation, interview, and record review the facility failed to assess, document, notify the provider, and monitor an injury of unknown origin for 1 of 3 residents (R1) reviewed for quality of care in the sample of 5. This failure resulted in R1 exhibiting signs of an injury (bruising, pain with movement of left arm) for three days before the facility notified the provider and obtained an order for an X-ray. R1's	S9999		

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S9999	Continued from page 2 X-ray showed a non-displaced fracture of her left humerus (upper arm). The findings include: On 7/3/25 at 11:01 AM, R1 was seated in a padded, reclining wheelchair. R1 had a sling to her left arm. V5 (Unit Manager) explained to R1 that we needed to look at her arm. V5 unhooked R1's sling, removed her left arm from the sling, and exposed the skin to R1's upper arm. R1 had yellow bruising noted to her entire left upper arm, from her shoulder down to her elbow. R1 was unable to tell the surveyor what happened to her arm. The surveyor asked if R1's arm hurt and she replied, "Only hurts when you move it." The facility's Final Report related to R1's injury of unknown origin showed R1 was found to have pain upon palpation of her left upper arm/shoulder area where results showed a fracture involving the head of the humerus with no displacement. This document showed that R1 had severe cognitive impairment and was unable to recall any falls or incidents. This document showed that R1's POA chose conservative treatment of this injury and she was treated at the facility. This document showed R1 does have non-verbal indicators of pain with movement. R1's Facesheet dated 7/3/25 showed diagnoses to include, but not limited to stroke with left sided weakness, diabetes, hypertension, dorsalgia, gastroparesis, osteoarthritis, macular degeneration, insomnia, anxiety disorder, vascular dementia, recurrent depressive disorder, and fracture of upper end of left humerus (6/20/25). R1's facility assessment dated 6/5/25 showed she had severe cognitive impairment and was dependent on staff for toilet hygiene, personal hygiene, bed mobility, and transfers. R1's Care Plan started 2/25/25 showed R1 needed assistance with daily ADL (Activities of Daily Living) care. This document showed R1 was a total mechanical lift with assistance of two staff for transfers and required total assistance of one staff for bed mobility. R1's Pain Care Plan initiated 6/20/25 showed R1 had a fracture to her left humerus (upper arm) which	S9999		

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S9999	Continued from page 3 places her at risk for uncontrolled pain. R1's Progress Notes dated 6/20/25 showed, "While CNA (Certified Nursing Assistant) was getting [R1] up and ready, she noticed that her skin on her left upper arm was yellow from shoulder to elbow. Writer noted that she had a small bruise on her left arm on the 18th. (there were no notes on 6/18/25 related to R1's bruise). NP (Nurse Practitioner) notified. 2 view X-ray ordered. Incident Report was complete..." This note was modified on 6/21/25 at 12:45 PM (after the facility received R1's X-ray results showing a left humerus fracture). R1's progress notes did not contain any assessments or monitoring of R1's bruise to her left arm prior to 6/20/25 (Staff interviews showed R1's bruise was first reported 6/17/25). R1's Skin Evaluation Form dated 6/20/25 showed R1 had a 30 cm x 15 cm yellow/reddish bruise to left arm from shoulder to elbow. This was the first skin assessment completed on R1's left arm. R1's Radiology Report showed the date of service was 6/20/25 and the results were reported on 6/21/25 at 5:50 AM. This reported showed R1 had a recent proximal left humerus fracture with no displacement. The R1's facility Investigation Notes showed interviews with staff were documented on 6/23/25 and 6/24/25. These notes showed that V9 (LPN - Licensed Practical Nurse) was notified of R1's bruise on 6/17/25. These notes showed V12 (CNA) reported a big yellow bruise to V7 (LPN) on 6/17 or 6/18/25. These notes showed V7 was notified R1 had a bruise on 6/17/25 during report. These notes showed V8 (RN - Registered Nurse) said R1 had an "8 cm bruise (red)," but had no idea how it happened. These notes showed V11 (CNA) returned from vacation on 6/18 and told V9 (LPN) she saw a bruise, but V9 said she already knew about it. These notes showed V5 (Unit Manager) was first made aware on 6/20/25 of a yellow bruise and red spot on top of R1's shoulder and lower upper arm and had the nurse call the NP for orders for an X-ray due to bruising and pain (three days later). R1's June 2025 MAR (Medication Administration Record) showed on 6/21/25 at 11:51 AM Tylenol 650 mg was administered for pain rated "4" on a 1 to 10 scale (10 being worst pain).	S9999		

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S9999	Continued from page 4 R1's Provider Note dated 6/23/25 showed R1 was seen for a follow-up and newfound humerus fracture. R1 was noted with a bruise and yellowing discoloration of her shoulder therefore an X-ray was obtained. The nursing staff was unaware of an injury and there were no recent falls. The X-ray showed a fracture involving the neck of the humerus with no displacement, the shoulder joint was grossly intact. This note showed R1's fracture was likely pathological and conservative treatment measures were initiated. R1 had an order for a sling, pain management, and recheck an X-ray in 4-6 weeks. On 7/2/25 at 2:58 PM, V6 (LPN) said he usually works 2nd shift on R1's hall. V6 said he wasn't sure of R1's orientation status because she doesn't talk to him much. V6 said he gives her medications and that's about it. V6 said last week there was an issue with R1's being bruised. V6 said they did an X-ray and R1 had a fracture. V6 stated, "We've all been racking our brains trying to figure out how that could have happened." V6 said whenever a resident has a new skin issue noted the nurse should immediately do an assessment on a Skin Assessment form and include a description of the wound and measurements. On 7/2/25 at 3:02 PM, V7 (LPN) said she floats all over the facility. V7 said when she has to take R1's blood pressure her arms seem very stiff. V7 said if a resident had a new bruise and was showing signs of pain then she would call the NP and notify them of the situation. V7 said she would follow the orders given by the NP. (The facility's Schedule showed V7 was R1's 3-11 PM nurse on 6/17/25 and 6/18/25. R1's EMR (Electronic Medical Record) did not contain documentation regarding R1's bruise prior to 6/20/25). V7 said she didn't recall when R1's bruising started and doesn't remember if she was in pain. On 7/3/25 at 8:57 AM, V9 (LPN) said she was assigned to R1's hall on 6/17/25. V9 said she was doing rounds when V10 (CNA) came and reported that R1's left arm was bruised and yellow when she got her up. V9 said she went in the room with V10. V9 said R1's whole deltoid was bruised and yellow. V9 stated, "I thought well that's an old bruise. I asked [R1] are you in any pain ,does it hurt. She said No. [V10] continued to get her up. My thinking was that it had already been addressed because it looked like an old bruise. When the oncoming nurse came in (V7-LPN), I did tell them in report. I	S9999		

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S9999	Continued from page 5 told her [R1's] arm is bruised, it's old, it's yellow. I'm not on the same hall everyday, so 3 days later I was on that hall again. The X-ray report came off the copier and it showed [R1] had a fracture. I was stunned because it was an old bruise. I proceeded to notify [V4-NP]. I notified her daughter and it was decided to do conservative treatment." V9 said R1 had a stroke and her left side is week. V9 said she didn't do full ROM (Range of Motion) because that's R1's stroke side. I did move her arm up off her breast and lifted her arm. She didn't complain of pain at that time. I don't know what happened and [R1] wasn't able to tell me. She can make her needs known and she could tell me if she was having pain. V9 stated, "That's all I know about it. I was gone on vacation. I saw it was an old bruise and wondered what the heck happened. That bruise should have been reported and addressed prior to me seeing it. It was yellow." On 7/3/25 at 10:36 AM, V8 (RN) said R1 knows herself, her daughter, and V8. V8 said R1 will say good morning to her and can answer yes or no questions, but her communication is limited at times. V8 said R1 had a stroke and she doesn't use her left arm. V8 said R1 can hold her left arm with her right when they use the total mechanical lift, but R1 is dependent on staff for most ADLs. V8 said she wished she remembers what the date was when she first saw R1's red bruise. V8 said R1 had an 8 cm, red bruise here (pointed to her left deltoid (upper arm area). V8 said she should have charted something, but she doesn't remember if she did or not. V8 said new skin concerns should be charted to keep track of the progress. V8 said a few days later R1's arm was yellow from her shoulder to her elbow. V8 stated, "I know I charted the yellow discoloration on 6/20/25." V8 said on 6/20/25 R1's CNA reported the yellow bruise to me and came in with me to look at R1's arm. V8 stated, "It was just a red bruise before and now it was all yellow from her shoulder to her elbow. It looked like the stage of bruise where it's starting to heal." V8 said V4 (NP) ordered a X-ray and R1's arm was fractured. V8 said she was not aware that R1 was in pain. On 7/3/25 at 10:51 AM, V5 (Unit Manager) said if a resident had a new bruise, then the staff should report it to her, especially if it is big. V5 said a 6-8 cm bruise in an unexpected location or appearing suspicious would be concerning. V5 said she would expect the nurse to call the Provider and the resident's family. V5 said the nurse should document an assessment in the progress notes or on a Skin	S9999		

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S9999	Continued from page 6 Assessment. V5 said the nurse should document the assessment (size, appearance and location of the bruise), who they spoke with, the outcome, and any follow-up required. V5 said the purpose of documenting was to communicate with the care team and to track the progress of the wound. V5 said the nurse could review the notes to see if the Provider was aware of the bruise and what interventions or orders had been completed. V5 said she didn't see any notes regarding R1's bruise prior to 6/20/25. V5 said R1's first skin assessment was the one she completed. V5 said she would expect that R1's bruise was documented when it was found. V5 said she had no idea what happened to R1's arm. V5 said she wasn't notified of R1's bruise until 6/20/25. V5 said she had the nurse call the Provider and that was when the X-ray was ordered. V5 said bruises usually start a red or purple color then the colors and shape will change throughout the healing process. V5 said a yellow bruise means it's healing and happens later in the process. V5 said R1 was on blood thinners and she would expect that her bruise was documented when it was found and properly follow-up was completed. V5 said the CNAs should be observing the resident's skin during care and reporting any concerns to the nurse. On 7/3/25 at 11:14 AM, V10 (CNA) said she returned to work after some time off and saw R1's arm was a weird yellow color. V10 stated, "I didn't know what it was and I reported it right away to the nurse. I went in with the nurse and she said, "oh that's an old bruise." She said she was going to check the chart, but I never heard anything. She didn't seem too concerned, so I forgot about it. Days went by and I heard she (R1) broke her arm. It's so weird." V10 said R1 doesn't talk a lot, but she can answer yes or no. V10 said R1 needs total assistance with all care. V10 said night shift will usually get R1 cleaned up and dressed and the day shift will get her up in the chair for breakfast. On 7/3/25 at 1:09 PM, V12 (CNA) said she R1 will communicate with you if you make eye contact and give her time to answer. V12 said if you don't, then she will hold her head down and say nothing. V12 said R1 was total care because one side is paralyzed. V12 said she saw a bruise on R1 and reported it to V7 (LPN). V12 said R1's upper arm was yellow and darkish in color in the back of her arm. V12 said the discoloration when into her left shoulder. V12 said she asked R1 if she hurt her arm and she didn't answer. The nurse said they knew about it. She didn't do anything. V12 said when R1 is turned side to side for care, she will tense up her	S9999		

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S9999	Continued from page 7 body. V12 said R1 usually gets up for breakfast and stays up until 1:30, then she lays down until dinner and goes back to bed around 6:30 PM. V7 said R1 can answer yes or no questions, but she isn't very conversational. V12 said a week after she reported the bruise to V7 she found out R1 had a broken arm. V12 said she showed V7 R1's shoulder and everything and she said they knew. She didn't seem concerned about it. On 7/3/25 at 1:22 PM, V11 (CNA) said R1 only speaks one or two words but could make her needs known. V11 said she might night be able to relay the full details, but you could figure out what she wanted. V11 said R1 was paralyzed on her left side, was total care, and required a lift to get out of bed. V11 said she was on vacation and returned to work on 6/18/25. V11 stated, "I reported to the nurse and I was told it was something old. The nurse told me that [V10-CNA] had mentioned it a couple days before. There was no bruise before my vacation, but when I came back, I noticed it. I asked her what happen and she didn't say anything. When we turn her side to side she would say, "Ow, my arm hurts or Ow my arm." The bruise was green, yellow, and purple when I saw it. It was her shoulder and upper arm, near her arm pit. I think the nurse was [V9 - LPN], but she said she knew and had reported it. I assumed she did whatever she needed to do. Then after that we started to put a sling on her arm." On 7/3/25 at 1:31 PM, V15 (CNA) said she worked R1's hall 6/14, 6/15, and 6/16 and she didn't see any bruising. V15 said the following Monday (6/16) or Tuesday (6/17) she was helping a CNA get R1 out of bed and she pointed out the bruise on R1's arm. V15 stated, "I moved her (R1's) arm out just a touch to look at the bruising and she said, "Ow." I stopped moving her arm. She'd never done that before. The CNA was [V11] and I let the nurse know. [V8] was the nurse. I left the room and the nurse went in. V15 said she just moved R1's arm to see how far the bruising went and she said, "Ow." V15 said it looked like a big purple bruise on her bicep and it was yellow around it from her elbow to her shoulder. V15 said the CNAs look at the resident's skin during care and notify the nurse if they see anything unusual. V15 stated, "I'll make sure the nurse comes before I finish what I'm doing. I'm not on the floor often so I make sure to report concerns so it can get documented and checked on." On 7/3/25 at 1:58 PM, V17 (Quality Director) said she wasn't directly involved in the investigation but V2	S9999		

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S9999	Continued from page 8 (DON - Director of Nursing) was not available for interview. V17 said the facility was unable to determine the cause of R1's fracture. The surveyor asked V17 when the facility because aware of R1's bruise. V17 replied, looking at the Investigation Notes it looks like around 6/17/25. The surveyor asked V17 what the nurse was expected to do if there was a new 8 cm red bruise on a dependent resident's upper arm. V17 replied the nurse should update the Provider, try to determine the potential cause, and document an assessment of the bruise. The documentation should include the location, size, and appearance. V17 said the documentation is a form of communication across the care team and is done to make sure the bruise is resolving and spreading further. V17 said newer bruises are generally darker in color, like a purple or red color, and as the bruise goes through the healing process it turns different colors. V17 said if R1 complained of pain when her arm was moved, then that should have been reported to the Provider immediately. V17 said the nurse may need to give pain medications and obtain orders for an X-ray, especially if the bruise was larger in size. V17 said there should have documentation of R1's bruise assessment, provider notifications, and potential interventions prior to 6/20/25. V17 said an undiagnosed fracture could pain surrounding the area, the fracture could worsen, and not heal properly. V17 said the Event printout showed R1's bruise was reported on 6/20/25, but the staff should have reported it sooner. On 7/3/24 at 2:13 PM, V4 (NP) said she was familiar with R1's care and sees her regularly. V4 said she saw R1 after her fracture. V4 said she was unsure of the exact date, but she was notified by nursing staff that R1 had discoloration of left arm into her armpit. V4 said the nursing staff reported there had been no incidents or falls. V4 said she gave orders for an X-ray the day she was notified (6/20/25). V4 said R1 had a history of a stroke and moves minimally. V4 said R1's movement was restricted on her left side. V4 said due to R1's increased weakness on the left side and her history of stroke R1 was at a high risk of developing a pathological fracture. The surveyor asked V4 if the facility notified her prior to 6/20 of R1's pain with movement of her left arm and the bruising that was first noted 6/17/25. V4 said she was not notified of R1 bruise and pain with movement prior to the day she ordered the X-ray (6/20/25 - 3 days later). V4 said she would have expected the facility to notify her. The facility's Skin Identification, Evaluation, and	S9999		

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S9999	Continued from page 9 Monitoring Policy approved 5/2025 showed, "The purpose of this policy is to outline a method of identification, evaluation, and monitoring for alterations in skin integrity... Procedure: Licensed nursing associate will evaluate the skin integrity through a physical skin evaluation and use of the Braden Skin at Risk tool. Upon admission, weekly for three weeks, quarterly, and when a significant change is identified. The nursing assistant will observe the resident's skin when assisting with activities of daily living and report changes to the nurse... The Licensed Nursing Associate: A. Complete a General Skin Check to evaluated for changes in skin integrity. B. Document in medical record the finding of general skin check... a. Document integumentary findings. i. Appearance of the wound, including measurements... 2. If new wound is identified... b. Notify health care provider of findings for further treatment orders. 3. Notification/Education of resident and resident representative of finding and physician orders. 4. Document evaluation in medical record... The Certified Nursing Assistant (CNA) should: A. Observe skin for changes when assisting with activities of daily living... D. Report skin integrity changes to the nurse..." The facility's Change in Resident's Condition or Status Policy approved 1/2024 showed, "Our community shall promptly notify the resident, his or her health care provider, and representative of changes in the resident's medical/mental condition and/or status... Policy Interpretation and Implementation. A. The nurse will notify the resident's health care provider or physician on call when there has been an: 1. Accident or incident involving the resident. 2. Discovery of injuries of unknown source... H. The nurse will record in the resident's medical record information relative to changes in the resident's medical/mental condition or status..." (B)	S9999		