Illinois Department of Public Health

(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED				
		IL6008817	B. WING		C 01/25/2021				
NAMEOF	PROVIDER OR SUPPLIER	STREET AD	DRESS, 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 CORRECTIC (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE COMPLETE				
S 000	Initial Comments		S 000						
	Complaint Investiga	tion #2110303/IL130201							
S9999	Final Observations		S9999						
	Statement of Licens	sure Violations:	5	.E					
*	a) The facility sprocedures governing facility. The written be formulated by a large Committee consisting administrator, the admedical advisory conformation of nursing and other policies shall comply The written policies the facility and shall by this committee, diand dated minutes of the committee of the commi	dvisory physician or the mmittee, and representatives services in the facility. The with the Act and this Part. shall be followed in operating be reviewed at least annually ocumented by written, signed of the meeting.							
linois Depart	physician of any acc change in a resident health, safety or well but not limited to, the manifest decubitus u of five percent or mo The facility shall obta plan of care for the o	hall notify the resident's ident, injury, or significant 's condition that threatens the fare of a resident, including, a presence of incipient or alcers or a weight loss or gain are within a period of 30 days. In and record the physician's care or treatment of such		Attachment A Statement of Licensure Violations	25				
ABORATORY	DIRECTOR'S OR PROVIDE	R/SUPPLIER REPRESENTATIVE'S SIGNA	ATURE	TITLE	(X6) DATE				

(X2) MULTIPLE CONSTRUCTION

STATE FORM

K1RX11

If continuation sheet 1 of 7

PRINTED: 02/23/2021 FORM APPROVED

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: _ C IL6008817 B. WING _ 01/25/2021 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **4405 HIGHCREST ROAD** ASCENSION SAINT ANNE PLACE ROCKFORD, IL 61107 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DATE DEFICIENCY) S9999 Continued From page 1 S9999 accident, injury or change in condition at the time of notification. Section 300.1210 General Requirements for Nursing and Personal Care 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. Pursuant to subsection (a), general d) nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour. seven-day-a-week basis: 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 300.3240 Abuse and Neglect An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. These regulations are not met as evidenced by: Based on interview and record review, the facility failed to provide the necessary care and services for a resident with unrelieved knee pain and swelling, failed to notify a resident's physician of a resident's (R1) unrelieved knee pain and swelling. and failed to complete a medical evaluation on

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STATEMENT OF DEFICIENCIES		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY						
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:			COMPLETED						
					E C						
!L6008817		B. WING	11.00	01/25/2021							
NAME OF	ROVIDER OR SUPPLIER	STDEET AD	DECC CITY C	STATE, ZIP CODE							
NAME OF	ROVIDER OR SUFFLIER										
ASCENSION SAINT ANNE PLACE 4405 HIGHCREST ROAD											
ROCKFORD, IL 61107											
(X4) ID PREFIX		ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL)							
TAG	REGULATORY OR L	SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROF	PRIATE DATE						
				DEFICIENCY)							
S9999	Continued From page 2		S9999								
	that resident, which resulted in a delay in			53							
		ays, of a right femoral fracture									
	for R1. This applies to 1 of 3 residents (R1) reviewed for quality of care in the sample of 9.										
	The findings include	e:									
	R1's Resident Adm	ission Assessment showed R1									
- 10	* ** - N	e facility on January 8, 2021	}								
		swelling, bruising, or injury to									
	her right knee or le	g.		30 III 9	-						
·	Due Com Blom del	4-4-1		\$							
		ted November 20, 2020, gnitively impaired related to									
		ementia and Alzheimer's									
		plan also showed R1 "will		- 32 44							
	need assist of one staff for ADL's, two staff if										
6.7	using a lift (transfer	device) as needed."									
YA -	D4L More to a Mate	detail former 44,0004			100						
		dated January 14, 2021, R1 lying in bed, at 6:35 AM,]								
		nee with both hands. R1 was									
550		ing" with any movement of her									
	right leg. Upon assessment of the staff nurse, R1's "right lower extremity femur appears out of alignment with her right knee." The note showed an X-ray of R1's right knee was performed in the		j		2						
			-								
				0.							
		ving R1's X-ray results, R1 a local hospital for evaluation		10							
	and treatment.	a local nospital for evaluation			50						
	CHA COSCITOTAL										
	R1's right knee CT scan (computed tomography)										
report dated January 14, 2021 showed, "comminuted fracture through the distal right			- T								
	femoral shaft with 1										
	displacement."	ו אוומונ שיוויו ומוכימו									
	diopiacomoni				10.70						
		21 at 11:20 AM, V5, CNA,									
		R1 on January 13, 2021,									
	during the day shift	t. V5 stated, "Around 10:30	1								

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FORM APPROVED Illinois Department of Public Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: _ IL6008817 B. WING 01/25/2021 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 4405 HIGHCREST ROAD ASCENSION SAINT ANNE PLACE ROCKFORD, IL 61107 **SUMMARY STATEMENT OF DEFICIENCIES** (X4) ID PROVIDER'S PLAN OF CORRECTION (X5)(EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DATE **DEFICIENCY**) S9999 Continued From page 3 S9999 AM that day, I provided (R1) with incontinence care and was going to get her dressed. I went to bend her right leg to get her pants on and she began screaming in pain. She grabbed her right knee with both of her hands and held it. I knew something was wrong at that time so I stopped what I was doing and went to get the nurse." V14 stated he reported R1's knee pain to V6. Registered Nurse (RN), and V11, RN, on January 13, 2021. On January 19, 2021 at 11:40 AM, V11, RN, stated, "On January 13, 2021, (V5, CNA) reported to me that (R1) was having severe right leg pain. (R1) was not my patient that day so I told her nurse (V6, RN) that she was having right knee pain. I never assessed her that day." V11 also stated, "I did not notify (R1's) physician of her knee pain. I should have assessed her immediately that day and called her physician." On January 19, 2021 at 11:46 AM, V14, Certified Nursing Assistant (CNA), stated she cared for R1 on January 11, 2021. V14 stated, "I got her up out of bed that morning around 4:30 AM. I got her up by myself and used a gait belt. She didn't complain of any pain at that time. I put her in a wheelchair and took her to get weighed. I got her back into bed and she began rubbing her knees and complaining of pain." V14 stated she reported the R1's knee pain to the nurse on duty. On January 19, 2021 at 12:00 PM, V6, RN, stated, "I was the nurse for (R1) on January 13. 2021. I was notified that she was having knee pain that day. Around 1:45 PM, I went in to look ather knee. When I palpated her right knee, she

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had severe pain. I didn't do any range of motion (ROM) exercises with her right leg so I don't know if her ROM was normal for her...I did not call

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and that is significant. We should have called her doctor immediately when she began complaining

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condition, resident complaint of unrelieved pain, or complaint of new pain should be reported to a

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