STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6008379	A. BUILDING: _____ B. WING _____	R-C 11/01/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILLOW CREST NURSING PAVILION	515 NORTH MAIN SANDWICH, IL 60548

(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 First certification revisit to survey date 9/26/22	{S 000}		
{S9999}	Final Observations #1 Statement of Licensure Violations: 300.610a) 300.1210b) 300.1210c)3) 300.1210d)6) 300.1220b)2) 300.3210t) Section 300.610 Resident Care Policies a) The facility shall have written policies and procedures, governing all services provided by the facility which 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. These policies shall be in compliance with the Act and all rules promulgated thereunder. These written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, as evidenced by written, signed and dated minutes of such a 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	{S9999}	Attachment A Statement of Licensure Violations	

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{S9999}	Continued From page 1 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. Restorative measures shall include, at a minimum, the following procedures: c) Each direct care-giving staff shall review and be knowledgeable about his or her residents' respective resident care plan. 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. 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. 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 2 2) Overseeing the comprehensive assessment of the residents' needs, which include medically defined conditions and medical functional status, sensory and physical impairments, nutritional status and requirements, psychosocial status, discharge potential, dental condition, activities potential, rehabilitation potential, cognitive status, and drug therapy. Section 300.3210 General t) The facility shall ensure that residents are not subjected to physical, verbal, sexual or psychological abuse, neglect, exploitation, or misappropriation of property. These Regulations were not met as evidenced by: Based on observation, interview, and record review the facility 1) failed to ensure fall prevention interventions were implemented and failed to ensure the safety of a resident who was dependent on care from the facility. This failure resulted in R1 sustaining a hip fracture and R2 requiring emergency medical intervention and sustaining a displaced bilateral nasal bone fracture during a fall from bed.This applies to 2 of 4 (R1, R2) residents in the sample of 4. 2) Based on observation, interview, and record review the facility failed to ensure timely assessment and treatment of a resident with hip pain. This failure resulted in a 2 day delay of care for a resident with a hip fracture. This applies to 1 of 4 (R1) residents reviewed for care and services in	{S9999}		

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{S9999}	Continued From page 3 the sample of 4. The findings include: 1. On 10/31/2022 at 11:15AM, R1 was observed lying in bed on her back. R1 was confused and not able to answer questions. R1 was covered in blankets. V12 said R1 had her leg immobilizer currently in place. On 10/31/2022 at 12:03PM, V10 Certified Nursing Assistant (CNA) said she was working on 10/22/2022. V10 said on 10/22/2022 at approximately 7:00AM-7:30AM, V10 went to provide AM care to R1. V10 said R1 was incontinent and needed her (R1's) brief changed. V10 said she turned R1 on her side. V10 said she was standing on the right side of R1's bed and reached across R1 to grab the pad under R1's left side to roll R1 onto her right side. V10 said R1 gripped R1's left hip/upper thigh area tightly, grimaced, and said "ow" as she was being rolled onto her right side. V10 said she was the only staff member caring for R1 at the time. V10 said she finished getting R1 changed and dressed for the morning. V10 said she had V17 CNA come help assist her to transfer R1 to the wheelchair with the walker. V10 said she notified V11 Licensed Practical Nurse (LPN) between 7:40AM-7:50AM of R1's complaint of hip pain. V10 said R1 does not normally complain of pain. On 11/1/2022 at 1:13PM, V11 said on 10/22/2022 she was notified by V10 of R1's complaints of pain around 10:30AM-11:30AM. V11 said she contacted V13 Physician Assistant (PA) regarding the resident's complaint of hip pain sometime after lunch. V11 said she received an order for an	{S9999}		

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{S9999}	Continued From page 4	{S9999}		

x-ray of R1's hip on 10/22/2022 from V13. V11 said V12 Registered Nurse (RN) entered the x-ray order for R1 sometime in the afternoon on 10/22/2022. V11 said the x-ray company did not arrive at the facility on that day. V11 said the x-ray that was ordered on 10/22/2022 was not completed until the morning of 10/24/2022 at the facility. V11 said R1's x-ray results came back showing a possible fracture and R1 was to be transferred out of the facility to a local area hospital for evaluation. V11 said she observed R1 in the wheelchair around lunch time and R1 was transferred back to bed after lunch with the help of facility staff on 10/22/2022. V11 said she did an assessment of R1's leg after R1 was returned to bed sometime after lunch. V11 said she did a brief assessment while R1 was sitting up in the wheelchair during lunch. V11 said R1 "never" complains of pain and said this was a "significant change" for R1. V11 said after a resident has a significant change in condition an assessment should be completed. V11 said additional assessments should be completed every 2 hours after the change or more frequently as needed. V11 said this information would be documented in the nurses notes in the computer. V11 said she was unsure if that is how things were documented following R1's change in condition.

On 10/31/2022 at 11:18AM, V12 said on 10/22/2022 he called the x-ray company in the afternoon, and they told him they would be there to do the x-ray on 10/23/2022. V12 said R1 was up in the wheelchair during his shift on 10/22/2022. V12 said R1 does not complain of pain.

R1's progress note from 10/22/2022 entered at 16:28 (approximately 8.5 hours after V10 said she reported the pain) by V11 says "CNA reported

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{S9999}	Continued From page 5 to this writer that she noted resident guarding her left hip during cares and is complaining of some pain. Assessed resident left leg and hip for any signs or symptoms resident reports that hip area hurts unable for resident to complain in detail due to dementia. No redness noted to hip some +2 edema is noted to both legs and left leg remains straight with no inward or outward turn of foot. Notified [V13] with new order received to X-ray left hip." R1's progress notes from 10/24/2022 show an assessment of R1's leg was completed by V2 and was documented at 3:46PM. R1's progress notes show no other assessments of the resident's leg were completed on 10/22/2022 or 10/23/2022. R1's current physician orders show an order for x-ray which was ordered on 10/22/2022 and entered at 7:30PM. R1's nurses notes from 10/24/2022 at 10:00AM by V11 said "X-ray here to X-ray resident's left hip" R1's x-ray results from the x-ray completed at the facility on 10/24/2022 show "acetabular fracture with protrusion deformity of the proximal femur suspect (an acetabular fracture is a break in the socket portion of the "ball-and-socket" hip joint.)" These results were electronically signed at 10:19AM on 10/24/2022. R1's progress notes show no other assessments of the resident's leg were completed on 10/22/2022 or 10/23/2022. On 11/1/2022 at 10:56AM, V2 said after a change	{S9999}		

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in condition an assessment should be completed after the change. V2 said these assessments should be continued every 8 hours for the next 72 hours following the change in condition. V2 said they should be documented in the progress notes. V2 said the physician should be notified of the change in condition right away.

On 11/1/2022 at 12:20PM, V6 CNA said R1 requires a two person assist to roll the resident.

On 11/1/2022 at 8:49AM, V14 Radiologist said the type of fracture R1 sustained is "usually traumatic" and R1's fracture "does not appear to be pathological."

On 11/1/2022 at 3:20PM, V18 Emergency Room Physician said the type of fracture R1 sustained "would be associated with direct impact or trauma" and "would not be a pathological fracture." V18 said for the type of fracture R1 sustained, a person "should not be weight bearing on that type of fracture and it could make it worse." V18 said surgical options were discussed to repair the fracture with consulting physicians. V18 said due to comorbidities and the age of R1 that she was not a surgical candidate. V18 said R1 needed bucks traction and a follow up with the orthopedic specialist in 1-2 weeks.

R1's x-ray results from the x-ray completed at the facility on 10/24/2022 show "acetabular fracture with protrusion deformity of the proximal femur suspect (hip fracture)."

R1's hospital x-ray reports show on 10/24/2022 "There is abnormal widening of the left hip joint which appears chronic superimposed on this is a fracture of the medial wall of the acetabulum and some mild associated protrusion. The proximal

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femur appears intact."
R1's hospital x-ray results were documented at 6:49PM on 10/24/2022.

On 10/31/2022 at 2:40PM, V2 Director of Nursing (DON) said the facility has been having delays with the current company that is contracted to do x-rays with the facility. V2 said the remote location of the facility and staffing issues for the x-ray company have been factors in delays with x-rays for residents at the facility, usually on the weekends.

R1's current care plan shows "I, [R1], has an ADL self-care performance deficit r/t Alzheimer's, Confusion, Disease Process (SPECIFY), Fatigue, Impaired balance." R1's current care plan includes interventions for "BED MOBILITY: The resident requires extensive assistance by 2 staff to turn and reposition in bed every 2 hours as necessary," initiated on 4/13/2022 and was revised on of 5/11/2022. R1's current care plan also shows "PERSONAL HYGIENE: The resident requires extensive assistance by 2 staff with personal hygiene and oral care," initiated on 4/13/2022 and was revised on 5/11/2022.

2. R2's face sheet shows she is a 95 year old female and has diagnoses including: Alzheimer's disease, unspecified abnormalities of gait and mobility, weakness and history of falls.

R2's facility assessment dated 5/4/22 shows she has a severe cognitive impairment, and requires extensive staff assistance with her bed mobility and transfers.
R2's fall risk care plan initiated on 9/27/22 shows she is at risk for falls, has a history of falls, and

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her bed should be in the low position.
R2's fall risk assessments dated 5/17/22 and 10/25/22 show she is at risk for falls and both assessments show R2 has had falls in the past 3 months.

A post fall evaluation note completed by V8 (Registered Nurse/RN) dated 10/25/22 at 12:30 AM, shows that R2 had an unwitnessed fall in her room. The contributing factors section of that note shows that R2's bed was not at the proper height (not in low position), there was no bed rails on R2's bed and she did not have a fall mat down. That same note shows that R2 has a history of prior falls and similarities include self-transfers/rolling out of bed.

A nursing incident note dated 10/25/22 at 12:59 AM, completed by V2 (Director of Nursing/DON) shows that R2 was found by a Certified Nursing Assistant (CNA) lying on the floor next to her bed on her left side. She hit her head and a laceration and swelling was noted to R2's nose. A local ambulance company was contacted and arrived at 1:16 AM, and R2 was sent out to the emergency room for treatment.

R2's 10/25/22 Emergency Room (ER) report shows, R2 is presenting to the ER for trauma following a fall from bed and the report states, "She {R2} does have a history of trying to get up out of bed attended." The same report shows the following: R2 has bruising and swelling to the bridge of nose with a small abrasion to the left nare. A CT (Computerized Tomography) report shows R2 has a minimally displaced bilateral nasal bone fracture with adjacent soft tissue swelling.

On 10/31/22 at 11:05 AM, V4 (CNA) said the

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expectation for R2 and other residents who are fall risks is for their beds to be in the lowered position and fall mats down on the floor when they are in bed. V4 said the facility has gotten a lot of new staff who do not always know what to do.

On 10/31/22 at 11:35 AM, V3 (RN) said R2 is a fall risk and had a fall from bed which resulted in a fractured nose. V3 said R2 does try to get up on her own and should have her bed in the low position and a fall mat next to her bed.

On 10/31/22 at 12:24 PM, V6 (CNA) said she was working the night of 10/25/22 when R2 had a fall from bed. V6 said she did not find R2, another CNA (V7) found her on the floor. V6 said when she got to R2's room to assist V7 she saw that R2 did not have a fall mat down and her bed was not in lowest position. V6 said the staff who put R2 to bed should not have left her bed in the higher position.

On 10/31/22 at 12:38 PM, V7 (CNA) said on the night of 10/25/22 she walked past R2's room and found her laying on the floor, on her side next to her bed. V7 said she cannot speak for the staff who put R2 to bed but they should have left R2's bed in the lowest position, put her fall mat down, and neither were done when she found R2 on the floor.

On 10/31/22 at 2:45 PM, V2 (DON) said the facility uses interventions for residents at risk for falls which include: beds at the low position, fall mats, frequent checks, night lights, and keeping residents in the common area. She said the expectations are for staff to ensure these interventions are being done. V2 said the purpose of low beds and fall mats are to help reduce the

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{S9999}	Continued From page 10 impact of a fall. The facility's Fall Management Policy revised on 5/2015 states, "Based on previous evaluations and current data the staff will identify interventions related to the resident's specific risks and causes and try to prevent the resident from falling and to try to minimize complications from falling." The facility provided Fall Prevention Interventions list revised on 5/2015, include: Low bed and Floor mat beside the resident's bed. (A)	{S9999}		