Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6003842	A. BUILDING _____ B. WING _____	09/28/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILLOW ROSE REHAB & HEALTH	410 FLETCHER JERSEYVILLE, IL 62052

(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 Annual Licensure Survey	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.1210b)5) 300.1210d)6) 300.1220b)3) 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. 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.	S9999	Attachment A Statement of Licensure Violations	

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S9999	Continued From page 1 5) All nursing personnel shall assist and encourage residents with ambulation and safe transfer activities as often as necessary in an effort to help them retain or maintain their highest practicable level of functioning. 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. 300.1220 Supervision of Nursing Services b) The DON shall supervise and oversee the nursing services of the facility, including: 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. These requirements were not met as evidenced	S9999		

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S9999	Continued From page 2 by: Based on interview, observation, and record review, the facility failed to provide and implement interventions to prevent resident falls for one resident (R32) reviewed for resident safety in the sample of 27. This failure resulted in R32 transported to the hospital for a facial laceration with sutures and a fractured humerus on one incident, and a fractured hip with surgery on another incident. The Findings Include: 1. R32's Face Sheet, undated, documents R32 was admitted to the facility on 5/3/23. R32's medical diagnosis include Major depressive disorder, Dementia with behavioral disturbances, Anxiety Psychotic disorder, Hypertension, (HTN), Gastroesophageal reflux disease, (GERD), and Insomnia. The facility's Fall Analysis Log, undated, documents, R32 had a fall on 7/26/23, 7/27/23, and 8/28/23. R32's Fall Risk was entered into the Care Plan on 9/5/23 after R32 had several falls. There were no interventions added after each fall. R32's Care Plan, dated 9/5/23, documents, Falls: R32 admitted Hospice due to medical and physical decline. Diagnosis: Dementia, resident is non-mobile, assist with transfers, sits in geriatric reclining wheelchair, has risk factors that require monitoring and intervention to reduce potential for self-injury. Interventions: Attempt to anticipate needs - toileting, hydration, hunger and provide cares before resident attempts to fulfill on own, bring to nurses station when out of bed for	S9999		

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S9999	Continued From page 3 observation, assist resident to clean and place prescribed eyewear when awake, fall risk assessment quarterly and as needed with change in condition or fall status, keep call light within reach at all times, answer promptly and notify resident that help is coming, check every two hours when in bed for safety, side rails in up position while in bed to facilitate safe and more independent bed mobility. R32's Minimum Data Set, (MDS), dated 9/5/23, documents, R32 is cognitively intact and requires extensive assistance from two staff members for bed mobility, transfers, locomotion, toilet use, and bathing. R32 is occasionally incontinent of urine and always continent of bowel. R32's Nurses Note, dated 7/27/23 at 6:25 AM, documents, "Called to room to assess resident. Upon entering room, resident observed on floor sitting with back against bedside table. Incontinent of urine and shoes next to bed instead of on feet, lighting adequate, no apparent injuries noted at this time other than redness to left upper extremity (bicep) and to left side/back. VS, (Vital Signs): T, (temperature), 99.7, P, (pulse), 60, R, (respirations), 16, BP, (blood pressure), 115/77, SpO2, (oxygen saturation), 96% RA, (room air). Resident transferred to bed with gait belt X two assist. CNAs, (Certified Nursing Assistants), report she is weaker than normal. Neuro checks initiated at this time." R32's Nurses Note, dated, 7/28/23 at 3:45 PM, documents, "Returned from (local ER), tetanus shot given, Suture (6) to left eyelid, F/U, (follow-up), with provider in five days for removal and wound check. CT, (Cat Scan), of spine and head, Chest and Pelvic X-Rays which showed closed nondisplaced fracture of surgical neck of	S9999		

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S9999	Continued From page 4 right humerus (likely old); No medication order except OTC, (over the counter), Tylenol for Motrin take as according; Resident brought back to facility by Ambulance and two EMTs, (Emergency Medical Technicians), resident resting VS 98.2, 82, 18, 122/52, no signs of discomfort or pain, continue to monitor". R32's Nurses Note, dated 8/28/23 at 1:00 AM, documents, "Called to assess resident in room. Observed her sitting on floor next to bed facing lights on wall. C/O, (complained of), severe right hip pain. RLE, (right lower extremity), noted to be externally rotated and shortened. Unable to do ROM, (Range of Motion), or move it at all." R32's Nurses Note, dated 8/28/23 at 1:05 AM, documents, "EMS, (Emergency Medical Service), called to transport resident to ER, (Emergency Room), for evaluation." R32's Nurses Note, dated 8/28/23 at 1:15 AM, documents, "VS T-98.1, P-106, R-22, BP-140/102, SpO2-96%." R32's Nurses Note, dated 8/28/23 at 1:30 AM, documents, "EMS here and resident lifted from floor to stretcher via draw sheet and X two EMS with X three NH, (Nursing Home), staff." R32's Nurses Note, dated 8/28/23 at 1:35 AM, documents, "Report called to hospital. POA, (Power of Attorney), called and updated." R32's Nurses Note, dated 8/28/23 at 2:20 AM, documents, "(Local Hospital), called and admitting resident with Dx, (diagnosis): Right hip fracture. Message sent to MD, (Medical Doctor), DON, (Director of Nursing), POA said to call in AM, (morning), with updates."	S9999		

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S9999	Continued From page 5 On 9/27/23 at 11:30 AM, V2, DON, stated, "We only do a Quality Assurance Fall Analysis for residents fall. We don't do any other investigation on the falls." R32's "Quality Assurance Fall Analysis", documents, R32's had falls 7/26/23, 7/27/23, and 8/28/23. This document provides the "Root Cause Analysis Identified from the Investigation" and the "Prevention Plan" for each date of a fall. There is no fall investigation done on resident falls. R32's "Quality Assurance Fall Analysis", for fall on 7/26/23, documents, Root Cause Analysis Identified from the Investigation, as "Resident had previously returned from (regional hospital) where they said she fell on Psych unit. Had been given IM, (intramuscular), Haldol at hospital and has been unsteady since." Prevention Plan: "Med check and labs done by (Physician)." R32's "Quality Assurance Fall Analysis", for fall on 7/27/23, documents, Root Cause Analysis Identified from the Investigation, as "Resident on high dose of Depakote, unsteady. Was found to have gotten self out of bed", Prevention Plan: "(Physician) D/C's, (discontinued), Depakote with continued behavior monitoring." R32's "Quality Assurance Fall Analysis", for fall on 8/28/23, documents, Root Cause Analysis Identified from the Investigation, as "Got self out of bed without assistance. Bed alarm going off", Prevention Plan: "Low bed initiated." R32's Physician Order, dated 9/5/23, documents, "D/C Pressure Alarm while in bed and up in chair."	S9999		

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S9999	Continued From page 6 On 9/27/23 at 10:30 AM, V10, MDS Nurse, stated, "I am the one who puts in the fall risk assessments on residents. I do them quarterly. I don't do one after a resident fall, I only do them quarterly." R32's Fall Risk Assessment, dated 9/5/23, documents, R32 is a High Fall Risk with a score of 19. A score of 10 points or more = High Risk Score. R32's Fall Risk Assessment, dated 8/11/23, documents, R32 is a High Fall Risk with a score of 21. A score of 10 points or more = High Risk Score. R32's Fall Risk Assessment, dated 5/4/23, documents, R32 is a High Fall Risk with a score of 16. A score of 10 points or more = High Risk Score. On 9/25/23 at 9:48 AM, R32 is sitting in geriatric reclining wheelchair in her room by herself. R32 was not interviewable. On 9/26/23 at 3:40 PM, R32 is sitting at the Nurses desk in her Geriatric reclining wheelchair. The Facility's "Fall Prevention" Policy, dated 11/10/18, documents, "To provide for resident safety and to minimize injuries related to falls; decrease falls and still honor each resident's wishes/desires for maximum independence and mobility. 1. Conduct Fall Assessments on the day of admission, quarterly, and with a change in condition. 2. Identify, on admission, the resident's risk for falls. All staff must observe residents for safety. If residents with a high-risk code are observed up or getting up, help must be	S9999		

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S9999	Continued From page 7 summoned, or assistance must be provided to the resident. 3. Assessments of Fall Risk will be completed by the admission nurse at the time of admission. Appropriate interventions will be implemented for residents determined to be at high risk at the time of admission for up to 72 hours. 5. Immediately after any resident fall, the unit nurse will assess the resident and provide any care or treatment needed for the resident. A fall huddle will be conducted with staff on duty to help identify circumstances of the event and appropriate interventions. 6. The unit nurse will place documentation of the circumstances of a fall in the nurses notes or on an AIM for Wellness form along with any new interventions deemed to be appropriate at the time. The unit nurse will also place any new interventions on the CNA assignment worksheet. 7. Report all falls during the morning Quality Assurance meetings Monday through Friday. All falls will be discussed in the Morning Quality Assurance meeting and any new interventions will be written on the care plan". (A)	S9999		