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
	IL6008379	A. BUILDING: _____ B. WING _____	04/19/2016

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 Annual certification survey An extended was conducted.	S 000		
S9999	Final Observations Statement of Licensure Violations : 300.610a) 300.1210b) 300.1210d)6 300.2210b)2 300.2920e) 300.3240a) 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 300.1210 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	

Illinois Department of Public Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE 05/05/16

Illinois Department of Public Health

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S9999	Continued From page 1	S9999		

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 300.2210 Maintenance
b) Each facility shall:
2) Maintain all electrical, signaling, mechanical, water supply, heating, fire protection, and sewage disposal systems in safe, clean and functioning condition. This shall include regular inspections of these systems.
Section 300.2920 Mechanical Systems
e) Steam and Hot Water Systems. Supply and return mains and risers for cooling, heating, and process steam systems shall be valved to isolate the various sections of each system. Each piece of equipment shall be valved at the supply and return ends.

Section 300.3240 Abuse and Neglect
a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. (Section 2-107 of the Act)

These requirements are not met as evidenced by :

Based on observation, and interview, and record review, the facility failed to ensure a safe environment for residents when water in the resident bathrooms on the first floor measured between 125 and 140 degrees Fahrenheit (F). This failure placed the residents with a diagnosis

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S9999	Continued From page 2	S9999		

of dementia, on the first floor, at risk for second and third degrees burns.
This applies to of residents 2 of 13 (R6, R11) residents reviewed for safety in the sample of 22 and 12 residents (R30-R42) in the supplemental sample.
The findings include:
On April 12, 2016 at 11:25 AM, the water from the public sink near the nursing station was so hot, the surveyor could not hold her hand under the faucet for longer than one second. On April 12, 2016 at 11:50 AM, R30's hot water in the bathroom was measured at 135 degrees F. The water temperature from the sink in the first floor East hall shower room was measured at 130 degrees F. On April 12, 2016 at 12:10 PM, E3 (Maintenance Director) was notified of high water temperatures. Using a thermometer that was ice bath verified accurate to 32 degrees F, with the surveyor, E3 measured the following temperatures on the north hall of the first floor: R42's bathroom sink water was 140 degrees F, and R35's bathroom sink water was 140 degrees F. R6's bathroom sink water was 136 degrees F, and R34's bathroom sink water was 130 degrees. On the East hall of the first floor, R30's bathroom sink water was 138 degrees F, and R11's bathroom sink water was 125 degrees F.
Facility documentation provided on April 12, 2016 showed R34-R40 have a diagnosis of dementia and reside on the first floor. Additional documentation showed R34-R40 use the bathroom independently.
On April 12, 2016 at 12:50 PM, R30 was asked about the water temperature in his bathroom sink. R30 stated, "Damned right it's hot! It'll scald you ... it's just hot, hot water."
On April 12, 2016 at 12:35 PM, R33 stated she uses her sink to wash her face and brush her teeth, and when the water is hot, she has to

Illinois Department of Public Health

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S9999	Continued From page 3	S9999		

remember to turn on the cold water with the hot to prevent burning.
On April 12, 2016 at 1:00 PM, R31 stated if she didn't turn the cold water on, the water from her bathroom faucet would be too hot.
On April 12, 2016 at 11:45 AM, E5 Licensed Practical Nurse (LPN) refused to put her hand under the running water, and stated "I know it's too hot." E5 added she thought the water had been that hot for a "couple of weeks." E5 stated she "mentioned" the hot water concern to E3 (Maintenance Director). E5 added that [R37] occasionally uses the public sink to wash her hands. R37's April Physician Order Sheet shows she has a diagnosis of dementia.
On April 12, 2016 at 3:10 PM, E6 RN (Registered Nurse) stated she had put her hands under the hot water at the public sink earlier and she had to pull them back because of the hot temperature. E6 added she didn't think to tell maintenance about it.
On April 12, 2016 at 2:55 PM, E3 stated the scald alarm should go off at 115 degrees Fahrenheit. E3 confirmed when he was notified of the high water temperature, the scald alarm in the laundry did not go off.
On April 12, 2016 at 1:45 PM, E3 stated most of the safety alarms in the facility are monitored, including the fire alarms and the fire panel, but the scald alarm is not monitored. E3 stated he did not have a procedure in place for routinely checking the scald alarm. E3 stated he thought the scald alarm would sound.
On April 13, 2016 at 8:35 AM, E3 stated the last water temperatures recorded were on Friday, April 8, 2016. The water temperature log was reviewed and showed the last water temperature recorded was on Friday, April 8, 2016.
On April 12, 2016 at 2:30 PM, E8 (Laundry Aide) stated the scald alarm has sounded in the past.

Illinois Department of Public Health

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S9999	Continued From page 4	S9999		

E8 stated, "When it goes off, I press the acknowledgment button and notify [E3] (Maintenance Director)." E8 stated the alarm went off a couple of weeks ago.
On April 12, 2016 at 3:00 PM, E3 (Maintenance Director) stated he does not remember being notified of the scald alarm going off.
The Center for Medicare and Medicaid' State Operations Manual, appendix PP, as of February 6, 2015 has a Time and Temperature Relationship to Serious Burns table showing that a water temperature of 140 degrees F with an exposure time of 5 seconds can cause a third degree burn.

Based on observation, interview, and record review the facility failed to ensure resident safety by not ensuring a resident with a history of falls was transferred in a safe manner, and failed to supervise a resident at risk for falls, in the bathroom. The facility failed to ensure storage rooms containing biohazardous waste were locked to prevent access by confused residents.

This applies to 1 of 13 residents (R7) reviewed for falls in the sample of 22 and 11 residents (R26-29, R34-R40) in the supplemental sample.
The findings include:
1. R7's MDS (Minimum Data Set) of January 18, 2016 shows R7 has severe cognitive impairment and requires extensive assistance with transfers, dressing, hygiene, and toileting.

R7's Fall assessment dated March 15, 2016 shows she is at a high risk for falls, has a history of falls, has unsteady balance, has dementia, and had a decline in her functional status.

R7's ADL (Activities of Daily Living) care plan, revised on March 15, 2016 shows R7 needs 2

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S9999	Continued From page 5	S9999		

staff to assist her with transfers.
R7's Fall care plan dated March 15, 2016 shows "Resident fell to right side during a transfer with a CNA -(Certified Nurse Assistant)" and "Resident will decrease risk of falls with transfers with a 2 person transfer with all transfers." The March 15, 2016 intervention shows "Re-eval transfer status and change to a 2 person transfer with all transfers to and from wheelchair, toilet, and bed." The February 8, 2016 intervention shows "do not leave alone in the bathroom."

R7's March 15, 2016 Quarterly Fall Intervention Assessment shows "Res exhibits a decline with self performance and transfers, weakness present and has decreased endurance to ambulate with assist...Transfer assessment re-evaluated to 2 assist with transfers. Will in-service nursing to decrease risk of falls with transfers."

The facility Fall monitoring report shows R7 had 15 falls from April, 2015 through March, 2016. The Fall report shows on April 27, 2015 R7 "slid off the toilet."

On April 14, 2016 at 11:50AM, E14 wheeled R7 to the bathroom doorway in her room. E14 transferred R7 from her wheelchair to bathroom, using a grab bar, and R7's legs were unsteady. After transferring R7 to the toilet and removing her pants and incontinence brief, E14 left R7 unattended and unsupervised on the toilet in the bathroom to go look through her closet. E14 could not see R7 from the closet location in the room. E14 then left R7's room, and stepped out into the hallway to ask someone to bring him supplies, while R7 was unsupervised in the bathroom. E14 said R7 was at a high risk for falls, and had good days and bad days. E14 said

Illinois Department of Public Health

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S9999	Continued From page 6	S9999		

"some days she is stronger than others" and she was "weak earlier today. E14 said when he was cleaning R7 earlier in the day her legs were shaking. E14 then had R7 stand using the hand rail, and pulled her pants up, and transferred her to the wheelchair.

On April 14, 2016 at 12:10PM, E23 (Licensed Nurse) said R7 is at a high risk for falls, and should be transferred with 2 assists at all times because she has had a significant decline ,and it is unsafe to transfer with 1 assist. E23 said R7 should "absolutely not" be left unsupervised in the bathroom.
On April 15, 2015 at 8:50 AM, E2 (Director of Nursing - DON) said R7' health has declined, and she is not as steady on her feet, is difficult to re-direct due to her dementia, and has no safety-awareness. E2 said R7 has been changed to a two person assist with transfers, due to her decline, and she is not able to bear weight as well as she used to. E2 said E14 should not have transferred R7 by himself, and should not have left R7 unsupervised in the bathroom, on the toilet.
At 11:55AM, E27 (Restorative Nurse) said she completes transfer assessments on residents quarterly, annually, or with an improvement or decline in condition. E27 said R7's most recent transfer assessment was completed on March 15, 2016 and the assessment determined R7 should be transferred with a 2 staff assist. E27 said R7 should not be left unsupervised in the bathroom.

The November, 2013 facility "Falls - Clinical Protocol" shows
After more than one fall, the physician or designee should review the resident's gait, balance, and current medications...A restorative

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S9999	Continued From page 7	S9999		

nurse or therapist should monitor the residents mobility status.

Based on the preceding assessment, the staff and physician will identify pertinent interventions to try to prevent subsequent falls and to address risks of serious consequences of falling. the fall prevention plan of care should be reviewed and updated with each fall.

On April 13, 2016 at 1:30 PM, during the environmental tour, the first floor soiled linen room was unlocked and able to be pushed open without a key or security code. Red bagged biohazard garbage was located inside the room.
On April 13, 2016 at 1:35 PM, E43 (Environmental Supervisor) stated, "This door should be locked. Someone forgot to push the lock on the door knob inside. This room needs a key to get in." At 1:35 PM, E1 (Administrator) said, "Yes, I would expect this door to be locked. Residents could be harmed in there."
On April 13, 2016 at 1:45 PM, the second floor soiled linen and clean linen rooms were unlocked and able to be opened without a key or security code. The soiled linen room contained red bagged biohazard garbage, an opened bag of powder form sheet rock patching compound, and an open five gallon bucket of joint compound. The clean linen room contained disposable razors and nail clippers. E42 (Housekeeper) said, "The aides should be locking these doors. The red biohazard bins contain used linens that are infectious. " At 2:00 PM, E25 (Certified Nurse Aide) said, "These doors should be locked so residents don't get into the dangerous items in there."
R26-R29 and R34-R40 were listed on the the facility produced list of wandering and confused residents.
The facility's second floor soiled utility room

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S9999	Continued From page 8 signage regarding biohazard storage stated: "Attn: all staff regarding red bags in isolation rooms (use for) blood, stool, urine and respiratory secretions." The facility's Storage of Isolation/Biohazard Garbage policy dated 11/2013 states: The double bagged garage should be carried to the locked soiled utility room on the designated floor and placed in the red biohazard barrel. The Facility's Storage of Personal Care Items Policy dated 12/4/2015 states: Direct care staff retrieve the supplies as needed from the locked clean utility room. Items will be stored in a safe and clean manner. (A)	S9999		

Imposed Plan of Correction

Facility Name : Willow Crest Nursing Pavillion, LTD.

Survey Date : April 19, 2016

Survey Type : Annual Health Survey

Violation : A

300.610a)

300.1210b)

300.1210d)6)

300.2210b)

300.2920e)

300.3240a)

Attachment B
Imposed Plan of Correction

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 300.1210 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.

Section 300.2210 Maintenance

b) Each facility shall:

2) Maintain all electrical, signaling, mechanical, water supply, heating, fire protection, and sewage disposal systems in safe, clean and functioning condition. This shall include regular inspections of these systems.

Section 300.2920 Mechanical Systems

e) Steam and Hot Water Systems. Supply and return mains and risers for cooling, heating, and process steam systems shall be valved to isolate the various sections of each system. Each piece of equipment shall be valved at the supply and return ends.

Section 300.3240 Abuse and Neglect

a) *An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident.* (Section 2-107 of the Act)

This will be accomplished by:

I. Provide education for all departments on facility's policy and procedures for prevention of incidents/accidents and safe environment, to include: 1) a review of the requirement to provide an environment that is as accident free as possible; 2) a review of the requirement to maintain water temperatures at levels not to exceed 110 degrees Fahrenheit, throughout at all times; 3) a review of the requirement that no showers or baths are given when the water temperatures exceed 110 degrees; 4) a review of how to test shower water temperature before giving a shower and what to do if the water is too hot; 5) a review of the requirement to transfer residents who need two-person assist ; and 6) a review of the requirement to keep soiled and clean linen rooms locked.

II. Maintenance Supervisor and/or his designees will take water temperatures at various locations in various receptacles at various times daily and document.

III. Maintenance Supervisor and/or his designee will check the scald alarm and mixing valve weekly.

IV. Administrator will conduct observations of the hot water temperature logs and scald alarm/mixing valve check logs twice a week for four weeks, then weekly thereafter to

ensure they are being completed, and that appropriate action is taken if water temperature is above 110 degrees.

Date of Completion: Ten days from receipt of the Imposed Plan of Correction.

06/01/2016/np