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 ______	C 09/26/2022

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 FRI of 9/3/2022/IL151456 FRI of 9/4/2022/IL151455 Complaint Investigation: 2217663/IL151559	S 000		
S9999	Final Observations Statement of Licensure Violations 300.610a) 300.1210b) 300.1210d)3)6) 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	S9999	Attachment A Statement of Licensure Violations	

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

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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:

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.

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 300.3240 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 were NOT MET as evidenced by:

Based on interview and record review the facility failed to assess, monitor, and identify a resident experiencing a change of condition following a

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S9999	Continued From page 2 fall. This failure resulted in a delayed identification of a left femur fracture. This applies to 1 of 3 resident (R2) reviewed for change of condition in the sample of 4. The findings include: R2's Physician Order Sheets dated through September 2022 showed she is an 88-year-old female with diagnoses including dementia with behavior disturbance, osteoarthritis in right knee, anxiety, abnormalities of gait and mobility, osteoporosis, and fracture of the left femur. R2's Minimum Data Set assessment dated June 16, 2022, showed her cognition was severely impaired, with no behaviors, no rejection of cares, requires two person assist with bed mobility, transfer, toileting, and limited range of motion to bilateral upper and bilateral lower extremities. V10's (CNA) statement dated 8/20/22 documents On August 20, 22 around 6:40 PM, she was walking down the north hall and she was passing (R2's room) and R2 was observed laying on the floor. She entered the room to make sure she was okay and called for help. V7 (LPN) and V14 (RN) R2's nurse responded. She rolled R2 from her left side onto her back and assisted V14 transferring R1 back to her wheelchair. R2's electronic medical record showed no assessments were documented for R2's fall on 8/20/22. R2's nurses' notes reviewed for August 2022 showed there were no falls documented. On 9/21/22 at 12:20 PM, V4 (Physician) said he was not notified of R2 having a fall. R2's fracture	S9999		

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S9999	Continued From page 3 can be caused by trauma. "It's a crazy case, I'm not sure what happened." The nurses note dated 8/23/22 documents R2 noted with difficulty transferring new orders for PT evaluation. R2's Physical Therapy Evaluation report dated 8/24/22 documents "exhibiting a decline in activities of daily living and functional mobility. Assessment identifies two performance deficits in transfers and ambulation due to deficits in bilateral lower extremity strength, functional activity tolerance, impaired standing balance ..." Standing balance= poor unable (total dependence). R2's baseline "mechanical lift." Care giver goals "to able to help her transfer and walk like before." The nurses note dated 8/31/22 documents R2 has been yelling very loudly for several days when staff try to move, change her, or even put a sheet on top of her. (There was no physical assessment documented at this time). The fax report to V4 (Physician) dated 9/1/22 documents "Can (R2) have something for increasing pain? She is calling out in pain and grimacing when she is sitting in her wheelchair and during cares. R2's SBAR (Situation Background Assessment Recommendations) form dated 9/4/22 documents increased lethargy, decreased intake, "Screams with cares." R2's MAR (Medication Administration Record) for August 2022 and September 2022 shows a pain assessment should be completed every shift, but the pain assessment form showed there was no	S9999		

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documentation completed on the pain assessment form until 9/4/22.

The nurses note dated 9/4/22 documents R2 yelling out in pain. At shift change the CNAs reported R2 would not straighten her left leg. Nurse assessed and found it was contracted, tried to straighten leg ....MD notified, and x-ray ordered.

The nurses note dated 9/5/22 documents left leg contracted and on 9/7/22 R2 was admitted to hospice. The nurses note dated 9/11/22 showed R2 expired at the facility.

R2's imaging report dated 9/5/22 showed acute displaced fracture of the left femur.

R2's electronic medical records showed there were no assessments performed until 9/4/22 when R1's leg was found to be contracted.

R2's Vitals Records showed no vitals were recorded on 8/20/22. Vitals were not performed until 8/26/22 and next on 9/1/22.

R2's Skin Evaluation reports showed there were no assessments documented until 9/10/22.

On 9/21/22 at 9:35 AM, V7 (Licensed Practical Nurse) said she was summoned to R2's room sometime last month and R2 was lying on the floor in her room near the bathroom. V14 (RN) and V10 (CNA) were in the room, and we assisted her back into her wheelchair. V14 was her nurse that day. If a resident has a fall nursing should assess the resident and post fall monitoring for 72 hrs. She cared for R2 after her fall and noticed a change from her norm and contributed that to her urinary tract infection. She

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did not perform a physical assessment on R2.

On 9/21/22 at 2:00 PM, V10 (CNA) said she was walking past R2's room and she was lying on the floor on her left side. She notified V14 (RN) R2's nurse asked V7 (LPN) to come to R2's room to help. We transferred her back into her wheelchair and she left the room. After R2's fall she required a mechanical lift for transfers, she used to be a sit to stand lift.

On 9/21/22 at 2:45 PM, V14 (RN) said she did not assess R2 when she was found on the floor.

On 9/21/22 at 2:22 PM, V13 (Physical Therapist) said R2 was referred to therapy because she had a decline and couldn't walk. When he assessed R2 she was not herself, she couldn't do anything.

On 9/21/22 at 1:48 PM, V11 (Agency CNA) he worked on 9/3/22 and in the beginning of the shift a day nurse called for help to reposition R2 in her wheelchair because she was sliding out of her wheelchair. After dinner time R2 looked very tired and she was not herself we transferred her with the mechanical lift and she could not sit in the sling properly we had to grip the sling because she was dead weight, her feet were positioned upward in the sling. Something wasn't right. She used to transfer using a sit to stand machine a week before, then I was told she is a mechanical lift.

On 9/21/22 at 1:22 PM, V7 (RN) said she was R2's nurse on 9/4/22. It was reported to her by the day shift R2 stayed in bed, but could not recall why. R2 was not acting right, she stayed in bed for my shift (2nd shift) as well. She had increased behaviors and seemed like she was in pain. At the end of my shift a CNA reported her left leg

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S9999	Continued From page 6 was bent and she could not straighten her leg. R2's left leg was contracted. She assess R2's leg prior to this. On 9/21/22 at 9:19 AM, V5(LPN) said post fall monitoring should be done for 72 hours and if staff notice a change in a residents condition they should notify the physician. New complaints of pain could indicate a change and nursing should perform an assessment. On 9/21/22 at 1:22 PM, V7 (RN) said on 9/4/22 R2 was upset and screaming, she was not acting right. On 9/21/22 at 2:42 PM, V3 (ADON) said R2 was showing signs and symptoms of pain, something happened to her. R2's SBAR (Situation Background Assessment Recommendations) form dated 9/4/22 documents increased lethargy, decreased intake, "Screams with cares." The facility's Change in a Resident's Condition or Status Policy revised 2013, states, " If any direct care staff note a change in the residents' condition they are to notify the nurse. The Nurse Supervisor/Charge Nurse will notify the resident's Attending Physician or On-Call Physician when there has been: An accident or incident involving the resident ..." The Fall Management Policy revised 2013 states, "1. Anytime a resident sustains a fall, a report of that occurrence is to be completed by the licensed nurse. 2. The person who identifies or finds the injured residents is to notify a licensed nurse immediately ...4. Based on the nurse's findings post occurrence treatment is executed	S9999		

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S9999	Continued From page 7 which may range from first aide to emergent transfer to the hospital. 5. The family and doctor will be notified of the occurrence. 6. Documentation will support the monitoring, findings, and action taken. 7. A separate accident/incident/ unusual occurrence report is to be completed ...8. Assessment protocol is to be followed to guide nurses in conducting and documenting post fall screenings. The facility's Pain Assessment and Management Policy dated 2020 states, "The pain management program is based on a facility-wide commitment to resident comfort. Pain management" is defined as the process of alleviating the resident's pain to a level that is acceptable to the resident and is based on his or her clinical condition and established treatment goals...Pain management is a multidisciplinary care process that includes the following: a. Assessing the potential for pain; b. Effectively recognizing the presence of pain;c. Identifying the characteristics of pain; d. Addressing the underlying causes of the pain; e. Developing and implementing approaches to pain management; bf. Identifying and using specific strategies for different levels and sources of pain; G. Monitoring for the effectiveness of interventions; and Rh. Modifying approaches as necessary...1. Document the resident's reported level of pain with adequate detail (i.e., enough information to gauge the status of pain and the effectiveness of interventions for pain) as necessary and in accordance with the pain management program. 2. Upon completion of the pain assessment, the person conducting the assessment shall record the information obtained from the assessment in the resident's electronic medical record...Reporting: Report the following information to the physician or practitioner: 1. Significant changes in the level of the resident's	S9999		

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S9999	Continued From page 8 pain ...3. Prolonged, unrelieved pain despite care plan interventions..." (A)	S9999		