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 _____	C 11/02/2021

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

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S 000	Initial Comments Complaint Investigation: 2147910/IL139590	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.1210b) 300.1210d)3)6) 300.1220b)3) 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	S9999	Attachment A Statement of Licensure Violations	

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S9999	Continued From page 1 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 300.1220 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	S9999		

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S9999	Continued From page 2 reviewed and modified in keeping with the care needed as indicated by the resident's condition. The plan shall be reviewed at least every three months. 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 regulations are not met as evidenced by: Based on interview and record review, the facility failed to implement progressive interventions to prevent falls and failed to notify the physician and obtain treatment orders in a timely manner regarding continued pain and decreased mobility after a fall for one of four residents (R3) reviewed for accidents/supervision/notification in the sample of 4. This failure resulted in R3 falling, remaining in the facility for multiple days after the fall, before being sent to the hospital with right leg pain and diagnosed with a fractured right hip requiring surgical intervention. Findings include: R3's Face Sheet, undated, documents R3 has diagnoses of Dementia, Parkinson's Disease and Repeated Falls. R3's Care Plan Problem, undated, documents R3 has impaired physical mobility related to his Parkinson's and Dementia. Care Plan Approach dated 3/4/21 documents one staff will assist R3 with ambulation, uses a walker and gait belt. R3's Care Plan Problem, undated, documents R3 has "Self care deficit and needs supervision and/or assist to complete quality care and/or poorly	S9999		

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S9999	Continued From page 3 motivated to complete ADL's (Activities of Daily Living)." Care Plan Approach, dated 3/4/21, documents "Assist to transfer resident using one staff assist. Use gait belt for all hands on transfers from one surface to another. Explain all procedures prior to starting. Advise Resident what is expected of him/her during the transfer. Reassure Resident of safety as needed." R3's Care Plan Problem, undated, documents "Resident does not understand mobility limits due to cognitive limitations. Resident has been known to attempt to get up from chair unattended. Resident has been noted to attempt to get out of bed unattended." The Care Plan Approaches, all dated 3/4/21, document the following: "Assist resident to clean and place prescribed eyewear when awake; Encourage Resident to sit in areas well supervised by staff that also afford opportunity for increased socialization and distraction; Transfer to straight back dining chair for meals as Resident allows; Encourage and assist placement of proper non-skin footwear while out of bed; and Resident prefers to be provided privacy during toileting but has potential to attempt to get up while unattended- Remain with resident." R3's Minimum Data Set, dated 7/9/21, documents R3 has moderate cognitive impairment. The MDS documents that R3 requires limited assistance of one person for transfers and bed mobility. The MDS documents R3 is not steady and only able to stabilize with staff assistance with moving from the seated to standing position, walking, turning around and facing the opposite direction while walking, moving on and off toilet and surface to surface transfers. The Facility Fall log documents R3 fell on 6/4/21, 8/15/21 and 10/22/21.	S9999		

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S9999	Continued From page 4 R3's Nurse's Notes, dated 6/4/21 documents R3 had a witnessed fall resulting in a skin tear to the left hand. The Nurse's Notes did not document any interventions implemented after this fall. There is no documentation in R3's Care Plan that the facility implemented and documented progressive interventions to address this fall and prevent R3 from future falls. R3's Nurse's Notes dated 8/15/21, documents R3 fell while walking from room to hallway, resulting in skin tear to R3's elbow. The Nurse's Notes did not document any interventions implemented after this fall to prevent R3 from falling in the future. There is no documentation in R3's Care Plan that the facility implemented and documented progressive interventions to address this fall and prevent R3 from future falls. R3's Nurse's Notes document on 10/21/2021 at 9:20 AM, R3 fell when attempting to stand up from R3's wheelchair and documented R3 was lying on R3's right side with arm tucked behind R3's back. The Note documented R3 sustained a reddened area to the right elbow and a small skin tear on the fourth finger. The Note documented the Director of Nurse's and the Physician were notified. R3's Nurse's Notes document on 10/22/2021 at 11:20 AM, R3 complained of pain to right leg and arm. The Note documented notification was sent to the Physician and an Xray was ordered. R3's X-ray report for his right hip, dated 10/22/21 documents Right Hip, "Chronic and degenerative	S9999		

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S9999	Continued From page 5	S9999		

changes. Short interval follow-up are [sic] recommended, if symptoms persist, as a nondisplaced fracture cannot be excluded."

R3's Nurse's Notes document on 10/23/2021 at 6:30 AM, R3 continues to complain of pain to right hip. The Note documented R3 refused pain medication. There was no documentation that R3's physician was notified.

R3's Nurse's Notes dated 10/24/2021 7AM-3PM shift, document "Res (resident) had pain in feet Tylenol 500 mg (milligrams) given. Aide reported more pain in R (right) foot. Pt (patient) assessed. R ft (foot) inward call to (V6, R3's Physician) at 1:50 PM awaiting call back. Will monitor."

R3's Nurse's Notes, dated 10/25/21 at 10:25 AM, document call placed to (V6's) office. The Note documented a message left about R3 complaining of pain to right leg.

R3's Nurse's Note, dated 10/25/21 at 2:30 PM, documented that V6's office returned call and would like R3 to go to emergency room for evaluation of right leg.

R3's Nurse's Note dated 10/25/21 at 5:00 PM documents R3 was admitted to the local hospital with a hip fracture and would require surgery.

R3's Hospital Report Radiology Report Exam, dated 10/25/21, documents R3 had a comminuted fracture of the right proximal femur through the trochanteric region.

On 10/29/21 at 11:10 AM, V3, Licensed Practical Nurse (LPN) stated she worked the weekend R3 fell. V3 stated that after R3 fell, R3 was not propelling himself around in R3's wheelchair as

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S9999	Continued From page 6 R3 usually did. V3 stated R3 complained of pain during this time. On 10/29/21 at 1:15 PM, V4, Certified Nurse's Aide (CNA), stated that after R3 fell R3 complained of pain when R3 was up in his wheelchair. V4 stated that R3 had complained a "whole lot" when they would get R3 up. On 10/29/21 at 2:52 PM, V5, CNA, stated "I could tell (R3) was in pain and I told the Nurse. (R3) stayed in bed for supper and (R3) is usually up in wheelchair. (R3) complained of pain all weekend. I told the Nurse. (R3) stayed in (R3's) bed all weekend." On 10/28/21 at 10:00 AM, V2, Director of Nursing, said R3 had witnessed fall on 10/22/2021. V2 stated "The notes say (R3) fell on 10/21/2021 but it was actually 10/22/2021. I saw (R3) fall. (R3) fell on (R3's) right side and (R3's) right arm was bent back behind (R3). We called the Doctor and (R3's) family. Xray was ordered. The Nurse would have faxed the results to the Doctor. I was not here all weekend to know (R3) was in pain. My expectation would be for the staff to use nursing judgement and send a resident to the Emergency Room if pain continued." On 10/28/21, at 1:50 PM, V2, Director of Nurse's was asked to see the facility's investigation of R3's falls and documentation of how the facility determined the root cause of R3's falls and progressive interventions. V2 responded that she was unable to give the surveyors that information as it is Quality Assurance containing the investigation, root cause analysis and interventions implemented. V2 stated that is prohibited by her corporate office.	S9999		

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S9999	Continued From page 7 The Facility's Fall Policy, revision date of 11/10/2018 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." The Policy documents"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 the fall in the nurses notes or on an AIM for Wellness form along with any new intervention deemed to be appropriate at the time. The unit nurse will also place any new intervention 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		