STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6010037	A. BUILDING: _____ B. WING _____	C 04/25/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILLOWS HEALTH CENTER	4054 ALBRIGHT LANE ROCKFORD, IL 61103

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S 000	Initial Comments Investigation of Facility Reported Incident of April 24, 2023/IL159047	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.1210b) 300.1210d)6) 300.3240a) 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 300.3240 Abuse and Neglect a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident.	S9999	Attachment A Statement of Licensure Violations	

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S9999	Continued From page 1 This REQUIREMENT is not met as evidenced by: Based on interview and record review the facility failed to supervise a resident with a history of exit seeking behavior. This failure resulted in R1 exiting the building sustaining a fall with injury for 1 of 3 residents (R1) reviewed for safety and supervision in the sample of 3. The findings include: R1's physician order sheet (POS) dated 4/23 show R1 has diagnoses that include dementia, anxiety, weakness, and hypertension. R1's plan of care dated 1/6/23 show R1 has cognitive loss/dementia. Impaired decision making related to short term memory impairment, disorientation to place and time, deteriorated ability to understand. R1's document entitled "At Risk Wander Assessment dated 3/17/23 show diagnosis: Dementia. Mental Status: Disoriented to Person, Disoriented to Place, Disoriented to time. Mobility: Able to transport self independently by walking." R1's Facility Reported Incident (FRI) Initial dated 4/24/23 show, "Resident was found outside on property and brought inside. After assessment resident was found to have a hematoma to forehead, abrasion, and skin tear to forearm. No complaints of pain, extremities with full ROM. Blankets given to resident. Resident sent to a local hospital Swedish American hospital for evaluation. Family and physician notified."	S9999		

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R1's Incident Report dated 4/24/23 timed at 05:00 show, "Location: Outside Arbor main entrance. Describe the incident: Willow Arbor kitchen staff finding Harbor Lights resident on ground in front of main entrance door. Resident description: confused. Staff action: called 911. Injury type: laceration."

R1's progress notes dated 4/24/23 by V3 (License Practical Nurse) show, "5:15 AM, this nurse requested for maintenance to check WA (Willow Arbor) dining room due to pull cord being activated. Nursing assistance requested. This nurse responded observed resident sitting in the dining room shaking cold to touch. 2 hematomas noted to right side of forehead, glasses pressed to the bridge of her nose, abrasions to forehead and right forearm noted, skin tear noted to left forearm by elbow. Wait staff (kitchen staff) was with the resident stated she was outside. Resident smiled and denied any pain. Moved extremities with no difficulty. Blankets quickly placed over resident to provide warmth. 911 called, remained with resident until ambulance arrived ..."

On 4/25/23 at 8:26 AM, V3 (License Practical Nurse/LPN) said she was working 10PM-6:30 AM on 4/24/23. V3 (LPN) said at around 5 in the morning, she heard an alarm that does not normally go off. V3 said she radioed (walkie talkie) V4 (Maintenance) to check the alarm. V4 responded to let V3 know there was a resident (R1) by the Arbor Dining Room. V3 then radioed V7 (agency LPN) who was R1's nurse to check on R1. V3 said she received another call from V4 that R1's nurse (V7) has not made it to check on R1. V3 said she then went to check R1. R1 was sitting in the Arbor dining room shaking

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complaining of being cold. V3 said R1 told her she went out to pick flowers. R1 was noted to have 2 hematomas to her forehead. V3 said R1 must have fallen due to the placement of her glasses pressed towards R1's nose. R1 was wearing a blouse and pajamas. V3 said she called 911 immediately and R1 was sent to the hospital. V3 said she notified V1 (Administrator) R1's family and R1's physician of the incident. V3 said the kitchen staff was the one who found R1 sitting in a crate outside the Arbor Dining room.

On 4/25/23 at 9:41 AM, V4 (Maintenance) said he came in to work at around 3:45 in the morning on 4/24/23. V4 said he was doing rounds inside the property checking lights. At around 5AM, a call came in over to his radio over a pull cord in the main dining room (Arbor Dining Room.) V4 said he went to check and found V5 (Cook) and R1 sitting in a chair just inside the dining room doorway. V4 said he radioed V3 (LPN) to inform her that R1 was found outside the building.

On 4/25/23 at 9:35 AM, V5 (Cook) and V6 (Dietary Aide) said on 4/24/23, they were coming in to work at around 4:50 in the morning R1 was sitting in a black crate outside the dining room door in the corner. R1 was shivering. V5 (Cook) said she took off her jacket and placed it over to R1. V6 (Dietary Aide) said she also took off her jacket and placed in in R1's legs. Both V5 and V6 took R1 inside and pulled the cord. Within 5-10 minutes, V4 (Maintenance) responded to the pull cord.

On 4/25/23 at 10:09 AM, V7 (agency LPN) said he was R1's nurse on 4/24/23 night shift. V7 (LPN) said he was so busy that night shift being assigned to 2 units. V7 said he was told there was an alarm going off and was told that R1 got

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out of the building. V7 said he was directed to go to Arbor Dining Room where R1 was found. V7 said by the time he made it to the Arbor Dining Room, R1 has been assessed by V3 (LPN) and R1 had been sent out to the hospital via 911.

R1's hospital records dated 4/24/23 timed at 6:37 AM, 92-year-old female who was found on the ground outside of her nursing facility at [nursing home]. Patient has a larger bruise to the top of her head. Is an extremely poor historian in the setting of severe dementia ...her wonder device went off at around 3 a.m. subsequently she was found by Cook who was coming to work outside of the facility on the ground although awake. Patient is awake and alert ...however patient is very confused to the events. Patient was admitted from the ED with swelling to forehead, bruise to forehead, elbows, and knees.

On 4/25/ 23 at 8:41 AM, this surveyor and V1 (Administrator) walked through the alarmed exit door where R1 exited the building going through the Breeze Way then to the alarmed door leading to the outside.
V1 said she had started her investigation yesterday (4/24/23) when the incident happened. R1 is a resident in the Harbor Lights unit. There was an exit door behind the nurse's station that was alarmed, and wander guard (device worn by a resident that will alarm if a resident attempts to exit a door that has the alarm system at that exit) alarmed. R1 had a wander guard due to R1 has a behavior of wandering in the past. R1 went through that alarmed door that leads to the Breeze Way- an enclosed walkway that connects the Skilled Unit to the Assisted Living Unit. When R1 was in the Breeze Way, there was another alarmed door going outside. R1 went through that door that led to outside. There was a

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S9999	Continued From page 5 walkway that was concrete but even pathway outside that connects to the Arbor Dining room. V1 said R1 remained in the property but got outside the building. V1 said the 2-kitchen staff that was coming in to work close to 5AM saw R1 sitting on a crate outside the Arbor Dining Room. The 2 staff pulled the dining room cord alarm which V3 (LPN) heard in her radio. V3 then notified V4 (Maintenance) to check the pull cord. V1 said R1 went through 2 alarmed exit doors. R1 was able to get outside the building without any staff noticing R1 until she made it to the Arbor Dining room which was approximately 328 feet. V1 said when an alarm goes off, all staff should go and respond to the alarm. V1 said elopement in-services and responding to alarm in services has started since yesterday. R1's plan of care with initiated date of 4/9/23 show Behavior Problem: [R1] may wander into other residents' room and or off the unit. [R1] may become combative when staff attempt to redirect her when wandering. According to Wunderground.com (Weather Underground) accessed on 4/25/23 the temperature in Rockford Illinois on 4/24/23 between 4AM to 6AM ranged from 28-29 degrees Fahrenheit. "B"	S9999		