STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146040	A. BUILDING _____ B. WING _____	03/12/2020

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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0689 **Level of harm -** Actual harm **Residents Affected -** Few	**Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to assess, monitor and implement progressive interventions to prevent falls for two of three residents (R1, R3) reviewed for falls in the sample of 6. This failure resulted in R3 having multiple falls sustaining skin tears, a laceration requiring sutures and a fractured cheek bone. Findings include: 1. R3's Face Sheet documents he was admitted on [DATE] with [DIAGNOSES REDACTED]. R3's Care Plan, undated, documented Resident has risk factors that require monitoring and intervention to reduce potential for self-injury. Risk factors include: Decreased cognitive awareness, [MEDICAL CONDITIONS], dementia, delusions/ hallucinations. As evidence by noted resident unsteady gait, balance deficits, and previous history of falls resulting in fracture. The Care Plan noted the following interventions, dated 6/6/19, to address this problem: Encourage and assist placement of proper non-skin footwear; observe for non-verbal signs of restlessness that may precipitate movement and attempts to stand/walk unattended; Attempt to anticipate needs-toileting, hydration, hunger and provide cares before resident attempts to fulfill on own; bring to nurse's station when out of bed for observation; Keep environment well-lit and clutter free; Remind of safety precautions and limitations as necessary; Low bed with mat on floor; Personal alarm on while in bed; Check position with cares and function each shift; Personal alarm while up in chair. Check position with cares and function each shift. R3's Minimum Data Set, dated dated [DATE], documents R3 required extensive assistance (resident involved in activity, staff provide weight-bearing support) of two plus person physical assistance for bed mobility and transfers. The MDS documents he had moderate impaired cognition. R3's Fall Risk assessment dated [DATE] documents R3 as high risk for falls. R3's Nurse's Notes dated 12/11/2019 at 10:30 PM documents R3 was found on floor lying on his right side in his bedroom. R3's Nurse's Note document R3 sustained a skin tear to his right elbow measuring 2.0 centimeter (cm) by 1.5 cm with steri-strips applied. This Nurse's Note does not document a root cause analysis of R3's falls. There was no documentation in R3's medical record if R3's personal alarm was sounding at the time of this fall or if fall interventions in the care plan were in place. There was no documentation R3's Care Plan was revised after R3's fall on 12/11/19 with progressive interventions to prevent R3 from future falls and injury. R3's Nurse's Notes dated 1/1/2020 at 1:50 PM documents R3 was noted in doorway on floor. R3's Nurse's Note documented he sustained a 2.5 cm laceration to his right brow and a bruise to his right cheek. R3's medical record has no documentation the facility identified a root cause analysis of R3's falls or if fall interventions on the care plan were in place at the time of the fall. R3's Care Plan was not revised until 1/9/20. Intervention dated 1/9/20, documented R3 was to have occupational therapy for therapeutic exercises, therapeutic activities, self-care, neuro re-education and group therapy. R3's Minimum Data Set ((MDS) dated [DATE] documents R3 has severe cognitive impairment and was frequently incontinent of bowel and bladder. R3's MDS documents R3 needs extensive assistance to transfer and total dependence with ambulation. R3's Nurse's Notes, dated 2/9/20, documents R3 attempted to stand up from wheelchair by nurse's desk. The Nurse's Note documented R3 stood up, lost balance and fell to floor to left side. The Note documented R3 sustained a skin tear by 2 inches at left elbow. This Nurse's Note does not document a root cause analysis of R3's falls. There was no documentation in R3's medical record determining if interventions on the care plan were implement and/or effective at the time of the fall. There was no documentation R3's Care Plan was revised after R3 fell on [DATE] with progressive interventions to prevent him from future falls and injuries. R3's Nurse's Notes dated 2/14/2020 at 4:00 AM documents R3 was observed in the bedroom on floor. The Nurse's Note documented R3 sustained a 1 cm cut above right eyebrow and the area was cleansed and three strips were applied to his right cheek. This Nurse's Note does not document a root cause analysis of R3's falls. There was no documentation in R3's medical record to determine if the care plan interventions were implemented and/or effective at the time of the fall. On 3/6/2020 at 1:20 PM V2, Director of Nurse's stated R3 has had several falls and is the only resident with a personal alarm. V2 stated when R3 fell on [DATE] at 4:00 AM, R3's personal alarm was not working. V2 stated there was no documented schedule to check function of personal alarms. R3's Nurse's Notes dated 2/14/2020 at 8:00 PM documents R3 fell out of bed and sustained a laceration to his upper right eye. The Note documented R3 was sent to the emergency room . There was no documentation in R3's medical record documenting a root cause analysis of R3's fall. There was no documentation in R3's medical record determining if the care plan interventions were implemented and/or effective at the time of this fall. R3's Nurses Notes documents on 2/14/2020 at 9:00 PM R3 went to the ER (emergency room). The Nurse's Note documented a CAT (computerized axial tomography) Scan was completed and R3 required sutures to his laceration R3's emergency room report dated 2/14/2020 document R3 required 6 stiches to his right eye area. There was no documentation R3's Care Plan was revised after R3 fell on [DATE] at 4:00 AM and again at 8:00 PM. The Care Plan did not document progressive interventions to prevent him from future falls and potential injury. R3's Nurse's Notes dated 2/15/2020 at 11:30 AM documents R3 was in dining room and stood up from chair and fell to the right. The Nurse's Note documented R3 sustained a 2.5 cm skin tear to right hand and 0.5 cm skin tear to right upper extremity. There was no documentation in R3's medical record the facility conducted a root cause analysis of this fall. There was no documentation the care plan interventions were in place/effective at the time of this fall. R3's Care Plan documents 2/15/2020 intervention as Tylenol 500 milligrams tablets every 4 to 6 hours as needed, apply ice to right eye laceration and remove sutures in 7 days. There was no intervention to address R3's need for increased supervision to prevent R3 from future falls and/or injuries. R3's Nurse's Noted dated 3/1/2020 at 1:30 PM that R3 was observed on floor. The Nurse's Note documented R3 sustained a left eyebrow laceration. The Nurse's Note documented R3 was transferred to ER. R3's ER report, dated 3/1/20, documents a CAT scan was completed and R3 had a left zygomatic (cheek bone) fracture. On 3/10/2020 at 2:40 PM V5 Certified Nurse Assistant (CNA) stated monitoring means they give verbal cues to R3 to sit down when R3 attempts to get up. On 3/10/2020 at 2:50 PM V6, CNA stated monitoring means R3 was to reposition every 2 hours and check for incontinence. On 3/6/2020, the surveyor requested information regarding the investigation of R3's falls on 12/11/19, 1/1, 2/9, 2/14 and 3/1/2020. On 3/6/20, at 1:15 PM V2 Acting Director of Nursing (DON) stated the facility would not give a copy of the residents Fall Report or Investigation to the surveyor due to the forms were part of their Quality Assurance Program (QA) and not to be given to surveyors. On 3/10/2020 at 10:20 AM V2 stated the Facility's corporation stated the QA forms such as Incident/Accident Reports or Fall Log we don't give to surveyors due to it is part of QA. 2. R1's Physician order [REDACTED]. R1's Fall assessment dated [DATE] documents R1 at high risk. R1's MDS, dated [DATE], documented he required no assistance with transfers. The MDS documented he was not steady but was able to stabilize without staff assistance for moving from seated to standing position, walking, turning around and acing the opposite direction while walking and surface to surface transfers. Nurse's Notes dated 12/22/2019 at 4:10 AM documents nurse called to R1's room. The Nurse's Note documented R1 was laying on floor in room and had an approximate a 1.5 cm by 1.0 cm laceration to forehead and complained of pain in left thigh. The Nurse's Note documented he was sent to the ER and was admitted with a left fractured femur

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

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 0689 **Level of harm -** Actual harm **Residents Affected -** Few	(continued... from page 1) (thigh bone). R1 was sent to the emergency room . There was no documentation in R1's medical record the facility conducted a root cause analysis of R1's fall. There was no documentation in R1's medical record that R1's care plan interventions were in place and/or effective at the time of R1's fall on 12/22/19. R1's Care Plan, undated, documented R1 was at high risk for falls, had fallen in his room, will not allow staff to assist him, has unsteady gait with impaired ambulation skills. The Care plan documented he will sit himself on the floor also. The Care plan Interventions, all initiated on 12/26/19, documents the following: encourage and assist placement of proper non-skin footwear; remind to lock wheel chair brakes; observed for non-verbal signs of restlessness; observe for unsteady/unsafe transfer or ambulation and provide stand by or balance support as needed; IDT review of ADL status and fall potential with changes in condition fall status. Report significant findings to MD for follow up; Provide activity supplies to keep busy, Resident enjoys smoking, in room activities of making signs and notes and decorating his room, music and TV; Keep room and Pathways clear and free of clutter; Keep call light within reach and educate to use and request any assist; remind of safety precaution and limitations as necessary; and bed against wall and bolster mattress to bed. R1's Nurse's Note documented he was readmitted to the facility on [DATE]. The Note documented he returned with 42 staples to his left leg incision. R1's Nurse's Note, dated 12/27/19 at 6:30 PM documented that R1 fell while trying to go from his bed to his wheelchair. There was no documentation in R1's medical record that R1's care plan interventions were in place and or/effective at the time of R1's falls. There was no documentation that the facility revised R1's Care Plan with progressive interventions to address R1's fall on 12/27/19 or prevent him from future falls. R1's Nurse's Notes dated 12/29/2019 at 2:15 PM, documented R1 attempted to stand to reach his toothbrush and slid to the floor on his buttocks in from of his chair. There was no documentation that the facility revised R1's Care Plan with progressive interventions to address R1's fall on 12/29/19 or to prevent him from future falls. R1's MDS dated [DATE] documents cognition intact and transfers with extensive assistance. R1's Nurse's Notes dated 1/5/2020 documents R1 attempted to stand, lost his balance and fell . siting on buttocks. There was no documentation that the facility revised R1's Care Plan with progressive interventions to address R1's fall on 1/5/20 or to prevent him from future falls. R1's Nurse's Notes, dated 2/18/20 at 9:30 AM, documented R1 attempted to get up on his own and fell to the floor. There was no documentation in R1's medical record the facility attempted to determine the root cause analysis of this fall to prevent R1 from future falls. The Care Plan was revised on 2/18/19, documented that staff should encourage R1 to be up for breakfast at 7:30 AM when staff assisting to get resident up and due to swallowing issues to be in dining hall for more supervision. On 3/10/2020 at 12:25 PM V4 Licensed Practical Nurse (LPN) stated prior R1 was independent with ambulation in room with holding on to something in room to walk until he fractured his hip. R1 now can't stand and refuses physical therapy. On 3/10/2020 at 2:40 PM V5 CNA stated they started toileting R1 every hour today (3/10/20) and that is how they will monitor him. The Fall Prevention Policy, revision date of 11/10/2018, documents To provide resident safety and to minimize injuries related to falls, decrease falls and still honor each resident's wishes/desire for maximum independence and mobility. The Policy documents Procedures: #2. Documents All staff must observe resident for safety. If resident with a high-risk code are observed up or getting up, help must be summoned, or assistance must be provided to the resident.