STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145712	A. BUILDING _____ B. WING _____	07/29/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
WILLOW CREST NURSING PAVILION	515 NORTH MAIN SANDWICH, IL 60548

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 0684 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide appropriate treatment and care according to orders, resident's preferences and goals.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure interventions were implemented for a resident for 1 of 6 residents (R1) reviewd for quality of care in the sample of 6. The findings include: On July 28, 2020 at 11:30 AM, R1 was sitting in her wheelchair, in her room. R1 was leaning slightly to the right, resting with her eyes closed. R1's bed has bilateral side rails in place. R1's Physician order [REDACTED]. R1's facility assessment dated [DATE] showed R1 was rarely/never understood; had short and long term memory problems; and required extensive assistance of two staff for bed mobility. R1's Assist Rail Screening dated February 5, 2020 showed R1 had an alteration in safety awareness and a history of falls from the bed. This assessment showed a recommendation to place assist rails on R1's bed. R1's Physical Device/Physical Restraint Informed Consent signed February 6, 2020 showed V11 (R1's POA - Power of Attorney) gave persmission to place right and left 1/2 rails. R1's Care Plan initiated February 5, 2020 showed, (R1) uses 1/2 side rail as an enabler to aid in bed mobility and safety. R1's COMS Post Fall Evaluation dated March 31, 2020 showed R1 experienced an unwitnessed fall. This document showed, .Upon entering the room resident was observed on floor between bed and wall, facing wall on left side with covers around legs .Resident had a bump on left side of posterior head .abrasion on left knee and abrasion on left hand . On July 28, 2020 at 12:55 PM, V8 (RN - Registered Nurse) said I remember hearing that R1 had rolled out of bed on March 31, 2020 and that she didn't have side rails on her bed, so I called maintence early that morning to put the side rails back on her R1's bed. R1's daughter was here visiting that day and was upset because she had side rails, but they were no longer on the bed. V8 said R1's family felt R1 needs the side rails to prevent her from falling out of bed. V8 said the Restorative Nurse assesses resident for side rails. V8 said once a resident is assessed to require side rails, then the nurse will call maitenance and let them know to place the side rails on the resident's bed. V8 said a nursing note is not entered once the side rails is place; it is just assumed the side rails are placed once the assessment is done and the consent is signed. On July 28, 2020 at 12:12 PM, V5 (Maintenance Director) said he does not document when side rails are placed on a bed. V5 said the nurses notify him when side rails need to be installed, but sometimes a resident gets moved and if he is not notified by the nurse, then the side rails don't get moved to the new bed. On July 28, 2020 at 1:30 PM, V12 (CNA - Certified Nursing Assistant) said she was working on March 31, 2020 when R1 fell between her bed and the wall. V12 said R1 did not have side rails on her bed. On July 28, 2020 at 1:38 PM, V10 (CNA) said she was working with V12 on March 31, 2020 when R1 fell . V10 said R1 did not have side rails on her bed that night and stated, We complained and they (the side rails) were put on the next day. V10 said R1 had side rails before and she didn't understand why they were off the bed. On July 28, 2020 at 1:52 PM, V11 (R1's POA) said in February 2020 he signed a consent for R1 to have side rails and they were put on. V11 said R1 got a different bed and they never put the side rails back on. V11 stated, That's why she fell out of bed. On July 29, 2020 at 8:24 AM, V13 (LPN - Licensed Practical Nurse) said she worked the night R1 rolled out of bed (March 31, 2020). V13 said there were no side rails on R1's bed and she rolled between the bed and the wall, onto the floor. V13 said R1 did have side rails at one time. On July 28, 2020 at 1:57 PM, V2 (DON) said an assessment is done by the Restorative Nurse to determine if side rails are needed, then consent is obtained from the POA. V2 stated, If the care plan showed that R1 should have side rails, then the side rails should be on the bed. V2 said once the assessment and consent are completed, then the nurse informs V5 (Maintenance Director) and he will install the side rails. V2 said she does not keep track of the residents that have side rails in the facility. The facility's Proper Use of Side Rails Policy revised 11/2013 showed, 4. The use of side rails as an assistive device will be addressed in the resident care plan. 5. Consent for using restrictive device will be obtained from the resident or legal respresentative per facility protocol.

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.