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 _____	**08/11/2020**

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 0580 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to notify a resident's Power of Attorney (POA) when a resident was admitted to a higher level of care. This applies to 1 of 4 residents (R1) reviewed for notification in a sample of 4. The findings include: R1's Admission Record sheet, printed on August 10, 2020, showed R1 to be a [AGE] year old female with [DIAGNOSES REDACTED]. R1's Progress Notes dated May 29, 2020 showed R1 had a critically high potassium level. R1's physician ordered to send R1 out to a local hospital. R1 was admitted for cardiac observation and IV fluids. Resident was transported from the facility at 4:43 PM. On August 10, at 9:20 AM, V19 (R1's POA) stated on Monday June 1st she attempted to call R1. The staff told her she was not in the facility. V19 stated she contacted V7 (Social Services Director) to find out what happened. V19 stated she had no idea R1 was in the hospital. On August 10, 2020 at 9:50 AM, V7 stated she talked to V19 on Monday morning (June 1st). V7 stated V19 is the POA for R1, and was not notified of R1's transfer to the local hospital. V7 stated V19 should have been notified for R1's hospital admission. On August 10, 2020 at 1:05 PM, V13 (Wound Nurse) stated a resident's family/POA should be notified if a resident has a change in their condition like new wounds, falls, and being transferred to the hospital. On August 11, 2020 at 10:10 AM, V18 (Registered Nurse) stated a resident's POA should be contacted when a resident needs to go to the hospital. The Change in Residents Condition Policy revised November 2013, showed .Unless otherwise instructed by the resident, the Nurse Supervisor/Charge Nurse will notify the resident's family or representative (sponsor) when: .it is necessary to transfer the resident to a hospital/treatment center.
F 0689 **Level of harm -** Minimal harm or potential for 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 safely assist a wheelchair bound resident back into the building after smoking. This applies to 1 of 3 residents (R 1) reviewed for safety in a sample of 5. The findings include: R1's Admission Record sheet, printed on August 10, 2020, showed R1 to be a [AGE] year old female with [DIAGNOSES REDACTED]. R1's Fall Incident Report dated July 2, 2020, showed R1's fall occurred when R5 was pushing R1 in her wheelchair. R1's wheelchair wheel became stuck and R1 fell out of the wheelchair. R1 was educated to only allow staff to push R1 in the wheelchair. R1's Facility assessment dated [DATE], showed R1 was totally dependent on 1 person for locomotion on unit. R1's Care Plan printed on August 10, 2020 showed R1's focus areas to include: activities of daily living (ADL) self-care deficit, limited physical mobility deficit, and falls related to R1's medical [DIAGNOSES REDACTED]. R1's Progress Notes dated July 2, 2020 showed R1 was being pushed by R5. R1's wheelchair wheel got caught in a manhole cover. R1 was put back in the wheelchair using a mechanical lift. R1 had multiple skin tears and abrasions. On August 10, 2020 at 12:45 PM, V16 Certified Nursing Assistant (CNA) stated R1 needed to be pushed in her wheelchair. R1's left arm was affected by her stroke, and she could not move the wheelchair very well on her own. On August 11, 2020 at 12:30 PM, V13 Wound Nurse stated R5 had wheeled R1 in and out of the building before to go smoke. V13 stated R1 should have had staff bring her in and out for smoking times. On August 11, 2020 at 1:30 PM, V2 stated R1 should have been moved by a staff member before and after smoking. The Facility's Smoking Policy revised on March 2019, showed the residents are assessed for recognition, safety awareness, and any physical limitations that might cause an un-safe situation when smoking.

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.