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 _____	03/12/2020

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 0550 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to maintain resident dignity during personal cares and when a resident was lying in bed in their room for 2 of 18 residents (R287 and R82) reviewed for dignity in the sample of 18. The facility also failed to place a urinary drainage bag inside a dignity bag for one resident outside of the sample (R27). The findings include: 1. R287's admission record printed on 3/11/20 shows she was admitted to the facility with [DIAGNOSES REDACTED]. R287's Order Summary Report shows Monitor behaviors: Afraid/panic, agitated, angry, anxiety, crying, screaming/yelling, withdrawal, etc. R287's interim care plan shows she is cognitively impaired and is able to understand and communicate with staff. R287 was interviewable. R287's activities of daily living care plan show she has a self-care deficit and requires extensive to total assist of two staff members for bed mobility, dressing, toileting and bathing. On 3/11/20 at 11:26 AM, The door to R287's room was open. R287 was lying in bed with no covers and no incontinent brief on. For three minutes R287 was exposed from the waist down. During that time staff members were observed walking down the hall past R287's room. On 3/11/20 at 11:41 AM, V11 CNA (Certified Nursing Assistant) said R287 was exposed from the waist down when she went in to assist her. V11 said R287 had been restless that day. V11 said she left the brief off of R287 earlier because she thought the nurse was going to do something with R287's urinary drainage bag. On 3/11/20 at 3:15 PM, R287 said she did not like it when she was uncovered/exposed and the door was open earlier. R287 said she could see people walking by her room. On 3/11/20 at 3:25 PM, V6 (Restorative Nurse) said R287 is a new admission and she has been anxious. V6 said that on the previous day she had to pull the covers back up for R287 3 times because she kept uncovering herself. At 3:27 PM, V27 CNA said it was the first time she has worked on R287's hall. V27 said in the last hour and a half R287 has pulled her gown up three times. V27 said knowing that R287 does this she would make sure that R287 has briefs on and closes the door most of the way, leaving it only opened a little, so R287 is not exposed. On 3/11/20 at 2:37 PM, V3 ADON (Assistant Director of Nursing) said she would expect the staff to put a brief on the residents. V3 said when the nurse goes to do what is needed to be done with the urinary drainage bag, then the nurse could take the brief off. V3 said this should be done for the resident's dignity, especially since R287 has some cognitive issues. 2. On 3/12/20 at 10:30 AM, V11 and V13 certified nursing assistants (CNA's) were providing personal care to R287. V13 removed R287's sweatshirt and pulled down her incontinence brief. V11 and V13 then left R287 exposed from head to toe and went into the bathroom to get clean gloves. At this time, R287 was attempting to cover her breasts and vaginal area to keep them from being exposed. V13 then came back to R287's bedside and began washing R287's upper body. V13 then left R287 fully exposed again to return to the bathroom to get clean gloves. During this time, R287 again tried to cover her breasts and vaginal area with her hands. 3. R82's electronic face sheet printed on 3/12/20 showed R82 was admitted with [DIAGNOSES REDACTED]. R82's care plan revised12/27/19 showed R82 has incontinent episodes and requires staff assistance with toileting tasks. R82's facility assessment dated [DATE] showed R82 has moderate cognitive impairment and is incontinent of bowel and bladder. On 3/11/20 at 1:40 PM, V11 and V12 CNA's were providing care to R82. V11 and V12 removed R82's pants and incontinence brief and began providing perineal care. R82's buttocks and vaginal area were exposed for 12 minutes while R82's blinds to her room were open to the parking lot outside of the facility. During this time, several different people were seen walking through the parking lot outside and had an open view of R82's room where care was being provided. On 3/12/20 at 9:58 AM, V2 director of nursing stated, Dignity and privacy during patient care consists of calling a resident by their name, closing the door and blinds in a residents room and using blankets or towels to cover a resident in the areas where you are not providing care. On 3/12/20 at 10:23 AM, V11 CNA stated, In order to provide dignity during personal care staff should be closing the privacy curtains, blinds and door in each resident's room prior to initiating any cares. 3. R27's Admission record shows her [DIAGNOSES REDACTED]. R27's MDS (Minimum Data Set) shows she is cognitively intact and requires extensive assistance with all activities of daily living. R27's 3/2020 POS (Physician order [REDACTED]. On 3/10/2020 at 12:54 PM, R27 was sitting in her wheelchair in the dining room for lunch. R27's urinary catheter bag was not in the dignity bag, even though the dignity bag was under the wheel chair. Several CNA's (Certified Nursing Assistants) walked by R27 during lunch time without correcting the problem. On 3/11/2020 at 10:35 AM, R27 said she wants her urine bag in the dignity bag when out of her room. On 3/10/2020 at 1:15 PM, V3 ADON (Assistant Director of Nursing) said it was her expectation that all residents with urine bags be covered in privacy bags because it is more dignified for the resident. On 3/11/20 at 10:45 AM, V21 CNA said we use the dignity bag for the resident's dignity, and so other residents don't have to look at urine in a bag. The Urinary Catheter Care Policy and Procedure (revised 11/2013) shows: e. Maintain the urinary drainage bag in a privacy bag so other visitors and residents cannot view the bag. The Resident Rights Policy (revised 11/21/16) shows: 1. The resident has the right to a dignified existence .and Respect and Dignity. The resident has a right to be treated with respect and dignity, including: c. The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences . The 4/10/2011 Resident Privacy and Dignity Policy and Procedure shows, Purpose: To ensure that all residents are provided with dignity and privacy. To provide all residents with a home like environment that promotes dignity and respect to the residents of the facility. Policy: (3) Privacy will be maintained for all resident's receiving ADL's such as bathing, dressing and perinial care with the resident room/shower room door closed and curtain drawn.
F 0677 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide care and assistance to perform activities of daily living for any resident who is unable.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide oral care (R82) and failed to ensure a resident with scratching behaviors had trimmed fingernails (R62) for 2 of 2 residents reviewed for activities of daily living in the sample of 18. The findings include: 1. R82's electronic face sheet printed on 3/12/20 showed R82 has [DIAGNOSES REDACTED]. R82's care plan revised 3/15/18 showed, (R82) has an activitiess of daily living (ADL) self-care performance deficit related to complexities of medical diagnoses. (R82) requires supervision to limited assist of 1 for personal hygiene and oral care. R82's care plan created 3/1/20 showed, (R82) has a swallowing problem related to coughing or choking during meals and swallowing medications. Holding food in mouth/cheeks. Interventions showed staff are to check R82's mouth after meals for pocketed food and debris and provide oral care to remove debris. R82's facility assessment

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

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F 0677 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 1) dated [DATE] showed R82 has moderate cognitive impairment and requires assistance of 1 staff member for personal hygiene. R82's ADL report for 3/10/20 showed R82 received assistance with personal hygiene on 3/10/20 at 9:59 PM. On 3/10/20 at 11:43 AM, R82 was laying in her bed still in her nightgown with a pink and white substance coming out of her mouth and stuck to her cheek. V14 (registered nurse) stated, Oh that looks like some of her medication and some breakfast food coming out of her mouth. She shouldn't look like that. V14 then proceeded to scrub R82's face to get the substance off her mouth and stated, It looks like it's been there for a while but the CNA's (certified nursing assistants) are supposed to clean residents up each morning. I don't know the last time someone has been in here. On 3/12/20 at 9:58 AM, V2 (director of nursing) stated, Each resident gets morning care that includes bed bath (if needed), getting dressed, brushing teeth and brushing their hair. This care is not excluded to only mornings and is to be provided throughout the day as needed for each resident. At no time should a resident be seen with food, fluids or medications hanging out of their mouth. It is my expectation that all residents are clean and well groomed each day. On 3/12/20 at 10:23 AM, V11 (certified nursing assistant-CNA) stated, Every day residents are given personal care including washing their face, oral care, bathing, perineal care, dressing and any restorative exercises ordered. No resident should ever have food or fluids coming out of their mouth and left alone in their room. I don't remember when we went into R82's room the other day but it might not have been before you went in there. 2. R62's face sheet shows [DIAGNOSES REDACTED]. R62's Minimum data set (MDS) assessment dated [DATE] shows severe cognitive impairment. R62's assessment also shows total staff dependence needed for personal hygiene, including combing hair, brushing teeth, washing/drying face and hands. On 3/11/20 at 9:11 AM, R62 was lying in bed with her eyes open. R62 was unable to communicate verbally. R62 had four, dime size marks in various shades of red on her forehead. R62 had two, quarter size red scabs on her forehead. R62 was very bald and all the marks were clearly visible from the bedside. R62's nails on all ten fingers were long and growing well past the ends of the resident's finger tips. V15 (Certified Nurse Aide) said she did not know what the scabs and red marks were from. V15 said R62 is able to raise her arms up to her head and possibly that was the cause of the marks and scabbing. On 3/11/20 at 9:45 AM, V26 (Licensed Practical Nurse) stated R62 continually picks and rubs at her head. V26 looked at R62's finger nails and said yes, her nails are very, very long. They should not be like this. The aides are supposed to be checking resident nails daily during care. If they are long, aides should be cutting them. Aides are responsible for cutting nails as long as the resident is not a diabetic, which (R62) is not. On 3/11/20 at 10:28 AM, V25 (Certified Nurse Aide) said R62's forehead marks are from herself. She scratches herself a lot and causes cuts on her skin. V25 said R62's nails should be checked daily and clipped as soon as they become long. On 3/12/20 at 11:15 AM, V5 (Wound Care Nurse) said R62 does cause open areas on her skin every once in awhile. V5 said she has seen R62 scratching her head and does not have the cognitive ability to realize she is opening the skin up on her forehead. V5 said the way to prevent the scratches is to check her nails everyday and cut them as soon as they begin to get long. R62's care plan shows a focus area for impaired skin integrity related to skin sensitivity. Interventions include: ensure nails are clipped. The facility Care of Fingernails/Toenails policy date 11/2013 states under the general guidelines: 4. Trimmed and smooth nails prevent the resident from accidentally scratching and injuring his or her skin.
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 interview and record review, the facility failed to notify a physician of a change in condition for 1 of 3 residents (R86) reviewed during closed record reviews. The findings include: R86's electronic face sheet printed on 3/12/20 showed R86 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. R86's care plan created 4/5/17 showed R86 is at risk for falls related to confusion, decreased safety awareness and dementia. Interventions include frequent rounds when in bed, monitor for fatigue, unsteadiness, educate on safe transfer techniques, nonskid footwear when ambulating. R86's nursing progress notes showed the following: 1/2/2020 R86 went to the wrong room after dinner and fell down. She was found on the floor by kitchen staff. Nurse examined R86 on the floor. MD notified and advised to monitor and do neurological checks. 1/3/2020 R86 remains on fall follow up with neurological checks. No loss of consciousness noted. 1/4/2020 Neurological assessment intact, arouses easily for assessment. No complaints of headache, nausea, blurred or double vision. 1/4/2020 R86's physician updated with condition report in regards to resident's decline. New order received for Bilateral hip X-rays and labs. Resident remains on fall follow up with neurological checks. 1/4/2020 No fractures noted on x-ray. R86 remains very confused. R86 receives 1:1 supervision at mealtime. Neurological assessment within normal limits. 1/5/2020 1:00 AM Neurological checks and vital signs within normal limits for resident. 1/5/2020 8:02 AM At 5:30 AM Resident found unresponsive. Absence of pulse and blood pressure. Dried black blood noted on sheet and pillow. R86's neurological flow sheet showed on 1/2/20 at 6:43 PM R86's pupils measured 1millimeter (mm) on the left and 4mm on the right. At 7:00 PM pupil measurements were 3mm on the left and 3mm on the right. At 7:30 PM R86's left pupil was 3mm and the right pupil was 1mm. At 8:00 PM R86's left pupil was 4mm and the right pupil was 4mm. Neurological flow sheet at above times showed documentation that indicated all of R86's pupil assessments were equal. On 3/12/20 at 10:32 AM, V10 licensed practical nurse (LPN) stated, A physician would definitely be notified of differing pupil sizes. The initial pupil sizes are a serious difference and I would not hesitate to call the physician. This could indicate [MEDICAL CONDITION] or hemorrhage. On 3/12/20 at 10:39 AM, V3 assistant director of nursing stated, A physician needs to be notified immediately if pupil sizes are different, could be indicative of a head injury and the resident needs to be seen in the emergency room for further evaluation. On 3/12/20 at 1:05 PM, V9 LPN stated, R86 was sitting on the floor when she was found, I took the vital signs (blood pressure, temperature, oxygen and respirations) and called V24 (R86's physician). V24 stated that since R86 had no bruises to monitor her and do neurological checks. We were to notify V24 if there were any changes in R86's vital signs or neurological checks we were to call him back. R86's initial pupil sizes were a small change, she used glasses. This was not a change to be reported. When the pupils start dilating I would call a physician. On 3/12/20 at 1:25 PM, V24 (R86's physician) stated, I would expect to be notified of the initial pupil sizes for R86 and any difference on any further assessments. This could have been an indication of a brain bleed or trauma. If this had occurred on another resident that was younger and with better health this definitely could have impacted their treatment plan and I would have sent them out for further evaluation at an emergency department. Regardless of the fact that R86 had [MEDICAL CONDITION] and glasses, this was not a normal assessment and should have been reported to rule out any head trauma. The facility's policy titled Neurological Assessment revised 11/2013 showed, The purpose of this procedure is to provied guidelines for a neurological assessment: 1) upon physician order; 2) when following an unwitness fall .3. Any change in vital signs or neurological status in a previously stable resident should be reported to the physician immediately.
F 0686 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide appropriate pressure ulcer care and prevent new ulcers from developing.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to identify an area of pressure prior to it deteriorationg to an unstageable deep tissue injury for one of 3 residents (R74) reviewed for pressure injuries in the sample of 18. The findings include: R74's Admission Record printed 3/11/20 shows she has [DIAGNOSES REDACTED]. R74's order summary report shows an order for [REDACTED]. The care plan shows Monitor/document/report as needed any changes in skin status: appearance, color, wound healing, signs and symptoms of infection, wound size ., stage. R74's pressure ulcer care plan with a revision date of 1/14/20 shows she has an unstagable deep tissue injury to her left heel. R74's activities of daily living care plan shows she has an ADL self-care deficit and requires extensive assist of one staff member for turning and repositioning in bed, dressing, personal hygiene, toileting and bathing. The facility assessment dated [DATE] shows R74 has severe cognitive impairment and requires extensive assist of staff for bed mobility, transfers, dressing, toileting, personal hygiene and bathing. R74's 11/12/19 risk assessment for pressure ulcer development shows she was at risk. The Nurse progress notes dated 1/12/20 show a wound was discovered on R74's left heel measuring approximately one inch. The note shows a circular blister was noted to the medial aspect of R74's left heel. On 3/11/20 at 8:34 AM, V5 LPN (Licensed Practical Nurse/ Wound Nurse) performed wound care to R74's left medial heel. R74 had an area the size of a fifty cent piece on her left medial heel that was dark in color. V5 said it hurts sometimes. V5 said it was discovered as a deep tissue injury that was unstageable. On 3/11/20 at 2:59 PM, V3 ADON (Assistant Director of Nursing) said she would expect the staff to check the residents skin during AM and PM cares, during incontinence care and during showers and if the

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F 0686 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 2) resident complained of discomfort. V3 said she would expect them to identify an area of pressure prior to it becoming an unstageable deep tissue injury. On 3/12/20 at 9:52 AM, V3 ADON said in regards to skin monitoring, the staff know they are our eyes and ears and should be checking the residents skin with each encounter. V3 said the CNAs should let the nurse know right away if they see any skin concern so the nurse can assess the area, start a treatment and let the doctor and family know. On 3/12/20 at 12:59 PM, V27 CNA said it is important to check the residents' skin during cares to watch for redness and other skin concerns to prevent pressure ulcers and other skin irritations, and also to put interventions in place. At 1:06 PM, V10 LPN said it is important to check the residents skin during cares so you know if there is any new bruising or any new injuries. V10 added, Also to identify an area of concern early and put interventions in place to prevent further deterioration. The facility's skin evaluation form dated 1/14/20 show a deep tissue injury to R74's left heel measuring 5.8 centimeters (cm) x 7.5 cm. The Wound Evaluation and Management Summary dated 3/10/20 shows R74 has an unstageable pressure injury to left heel measuring 3.1 cm x 2.9 cm with thick adherent black necrotic tissue (non-viable, dead tissue). The facility's policy and procedure titled Prevention of Pressure Ulcers with a revision date of November 2013 shows Interventions and Preventative Measures: General .9. Routinely screen and document the condition of the resident's skin for any signs and symptoms of irritation or breakdown. 10. Immediately report any signs of developing pressure ulcer to the supervisor.
F 0690 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure urinary catheter tubing was not coming in contact with the floor on a resident with a history of a urinary tract infection for one resident (R27) outside the sample. R27's Admission record shows her [DIAGNOSES REDACTED]. R27's 3/2020 POS (Physician order [REDACTED]. R27's MDS (Minimum Data Set) shows she is cognitively intact and requires extensive assistance with all activities of daily living. On 3/10/2020 at 12:54 PM, R27 was sitting in her wheelchair in the dining room for lunch. R27's urinary tubing was in contact with the floor. Several CNA's (Certified Nursing Assistants) walked by R27 without correcting the problem. On 3/11/2020 at 10:35 AM, R27 said she has a urine infections in the past. On 3/10/2020 at 1:15 PM, V3 ADON (Assistant Director of Nursing) said it is her expectation that all residents with urine catheters, that the tubing should not be touching the floor, because that could increase the risk of infections. On 03/11/20 at 10:45 AM, V21 CNA said urinary catheter tubing should not be touching the floor, because it could increase the chance for infections. R27's 2/23/2020 Nursing Progress Notes shows a urinary analysis and culture and sensitivity result was called to the Physician. The Physician ordered antibiotics twice a day for 7 days, and for R27 to be on isolation for ESBL (Extended Spectrum Beta-Lactamase) infection. R27's 4/21/17 urinary catheter care plan shows to keep tubing off the floor. The Urinary Catheter Care Policy and Procedure (revised 11/2013) shows: b. Be sure the tubing and drainage bag are kept off the floor.
F 0755 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to reconcile receiving and administrating a narcotic medication for one of one resident (R238) reviewed for pharmacy services outside the sample. The findings include: R238's face sheet shows a facility admission date of [DATE]. The face sheet shows [DIAGNOSES REDACTED]. On 3/12/20 at 9:15 AM, the first floor medication cart was inspected with V22 (Registered Nurse). V22 unlocked the narcotic box in the cart. This surveyor inspected the medications in the narcotic box and cross referenced the medication cards to the count sheets. R238 had a bingo-type punch card and a count sheet each labeled Hydro/APAP 5 mg/325 mg ([MEDICATION NAME]-[MEDICATION NAME] 5 milligrams and [MEDICATION NAME] 325 milligrams). The directions stated take one tablet every six hours as needed. R238's bingo card showed four tablets missing with a remaining 20 tablets on the card. R238's count sheet showed that 25 tablets had been brought into the facility with her upon admission and zero tablets had been administered. The count sheet showed only one receiving nurse signature at the top of the form. On 3/12/20 at 9:30 AM, V22 stated she did not know why the tablets were missing. V22 said she did a full count of all the narcotics in the cart at the beginning of her shift with the night nurse. V22 said the night nurse must have given the tablets to the resident and had forgotten to record it. V22 said she had not given R238 any [MEDICATION NAME] during her shift. V22 said the narcotic boxes are counted with two nurses at the beginning and the end of all shifts. Both nurses sign a shift change accountability form which is kept at the front of the narcotic binder. This form was reviewed and showed the two nurse signatures. V22 said she thought the count was correct this morning, but she must have missed it. On 3/12/20 at 1:28 PM, V3(Assistant Director of Nurses) stated all resident medication should be reviewed and counted at the time of admission. V3 said narcotics like [MEDICATION NAME] need two nurses counting and signing the count sheets. Two signatures are needed when the narcotics first enters the building and between every shift change. V3 said having two nurses count and record tablets coming in ensures there is an accurate record of exactly what was brought into the building. R238's count sheet does not reflect two receiving nurse signatures. R238's count sheet does not reflect when or by who the missing tablets were given by. V3 said it is unclear exactly how many [MEDICATION NAME] tablets were brought into the facility with R238. On 3/12/20 at 1:36 PM, V2 (Director of Nurses) stated R238's [MEDICATION NAME] was brought into the facility by a family member. V2 said it is a facility expectation that all narcotics be counted and recorded on the controlled drug receipt form (count sheet) by two nurses. V2 said it should have been double signed when it arrived and it wasn't. V2 said the night shift nurse gave R238 [MEDICATION NAME] last night and forgot to record it. V2 said it is unclear how many tablets should be remaining. V2 said a second inaccurate count was performed this morning too. The night nurse and day nurse did not count R238's [MEDICATION NAME] correctly. V2 said it is important to have accurate and clear documentation of all narcotics due to their high risk for abuse. R238's March 2020 Physician order [REDACTED]. (V2 stated the missing [MEDICATION NAME] was administered on the 3/11/20 shift.) R238's [MEDICATION NAME] count sheet dated 3/11/20 shows directions for one tablet every six hours as needed for pain. The facility Controlled Substances policy revision dated 11/2013 states: 4. Controlled substances must be counted upon delivery. The nurse receiving the medication, along with the person delivering the medication, must count the controlled substances together. Both individuals must sign the designated controlled substance record. The policy further states: 9. Nursing staff must count controlled medications at the end of each shift. The nurse coming on duty and the nurse going off duty must make the count together. They must document and report any discrepancies to the Director of Nursing Services.
F 0760 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Ensure that residents are free from significant medication errors.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to prevent a significant medication error for one of seven residents (R84) reviewed for medications in the sample of 18. The findings include: R84's face sheet shows [DIAGNOSES REDACTED]. R84's March 2020 physician order [REDACTED]. R84's Medication Administration Record [REDACTED]. On 3/10/20 at 3:19 PM, V17 (Licensed Practical Nurse) checked R84's blood sugars and reported a reading of 150. V17 stated that requires 3 units of insulin per her sliding scale instructions. V17 went to the medication cart and was unable to located R84's insulin. V17 went to the medication room to check for the insulin and stated she did not have the insulin in the building. V17 called the pharmacy and requested the insulin be delivered on an emergency basis. V17 said the insulin will be delivered within one hour. V17 said she would give the insulin as soon as it arrives. V17 did not administer the insulin while the surveyor was present. On 3/12/20, R84's electronic Medication Administration Record [REDACTED]. On 3/12/20 at 12:03 PM, V2 (Director of Nurses) said medications are late if they are given more than one hour past the scheduled time. V2 stated it is especially important to give insulin at the time it is order because it directly affects blood sugar levels. Residents' blood sugar levels could become very high or very low if they do not receive insulin as needed. V2 said with improper insulin dosing, a diabetic resident could become hypoglycemic or hyperglycemic. V2 said medication refills should be ordered before a medication runs out. V2 said medication deliveries take up to four hours and receiving an order within one hour is not possible. On 3/12/20 at 12:15 PM, V3 (Assistant Director of Nurses) stated medication should always be given as ordered. If physician orders [REDACTED]. Insulin must be given at the correct time. It is a standard nursing rule. The facility Administering Medication policy revision dated 11/2013 states: 3. Medications must be administered in

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F 0760 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 3) accordance with the orders, including any required time frames. 4. Medications must be administered within one hour before and after their prescribed time, unless otherwise specified.
F 0811 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Ensure that residents are assessed for appropriateness for a feeding assistant program, receive services as per their plan of care, and feeding assistants are trained and supervised.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure resident assistants did not feed residents with a [DIAGNOSES REDACTED]. The findings include: R4's Admission Record printed 3/11/20 shows [DIAGNOSES REDACTED]. The facility assessment dated [DATE] shows R4 has severe cognitive impairment and is dependent on one staff member for eating. R4's order summary report shows he is on a pureed diet. R4's diet care plan shows he has a swallowing problem. The care plan lists many things staff have to monitor for during meals including shortness of breath, choking, labored respiration, lung congestion, pocketing, coughing, and making several attempts at swallowing. The care plan shows staff should use a teaspoon for eating and should alternate small bites and sips. R73's Admission Record printed 3/11/20 shows she had a [DIAGNOSES REDACTED]. summary report printed 3/11/20 shows she has an order for [REDACTED]. R73's nutritional care plan shows Monitor/document/report any signs or symptoms of dysphagia: Pocketing, choking, coughing, drooling, holding food in mouth, several attempts at swallowing, refusing to eat, appears concerned during meals. The facility assessment dated [DATE] shows R73 has severely impaired cognitive skills and requires extensive assist of one staff member for eating. On 3/10/20 at 12:35 PM, V20 (Resident Assistant) was in the dining room on the second floor feeding R4 and R73 lunch. Both R4 and R73 had a pureed diet. On 3/11/20 at 12:12 PM, V20 was in the dining room on the second floor feeding R4 and R73 their pureed meal. When asked what her job title was, V20 said she was a resident assistant. On 3/11/20 at 2:37 PM, V3 ADON (Assistant Director of Nursing) said a complicated feeder is someone that has chewing, swallowing, pocketing food, or decreased cognition concerns. A resident who is not able to tell you what is going on with them regarding issues with chewing and swallowing. V3 said she would say that a [DIAGNOSES REDACTED]. On 3/12/20 at 12:59 PM V27 CNA (Certified Nursing Assistant) said the CNAs and the Nurses should feed the residents with dysphagia to monitor for choking and swallowing issues. At 1:06 PM, V10 LPN (Licensed Practical Nurse) said the CNAs and Nurses should feed the residents with dysphagia to monitor for aspiration, choking and swallowing difficulty. On 3/12/20 at 8:39 AM, V23 Speech Therapist said R73 was having trouble masticating (chewing) her mechanical ground diet in 2016. V23 said because of this and she was diagnosed with [REDACTED]. V23 said R73's oral dysphagia had been remediated by downgrading her diet. V23 said R4 was admitted to the facility on a regular diet. About three years ago he was diagnosed with [REDACTED]. V23 said once the appropriate diet was in place for R4, he was not demonstrating any problems swallowing or propelling food down. The form titled Modified Diet List dated 3/10/20 shows R4 and R73 are on a modified diet of pureed. The facility's undated policy titled Resident Attendant shows Residents who have complicated feeding problems, including, but not limited to difficulty swallowing, recurrent lung aspirations and tube or [MEDICATION NAME]/IV feedings shall not be fed by resident attendants. The undated facility employee list provided by the facility shows V20 is a resident assistant.
F 0812 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to dispose of expired food in their emergency food supply. This failure has the potential to affect 86 residents in the building. The findings include: The Resident Census and Condition Report dated [DATE] showed 88 total residents in the building with 2 of the residents receiving artificial nutrition. On [DATE] at 10:12 AM, V8 (Dietary Manager) stated, Our emergency supply is used in the event that we had an emergency and do not have access to food. We rotate and go through our emergency supply every 3 months and dispose of our expired foods at that time. If we do not dispose of expired foods and they are served to residents, we increased the chance of foodborne illness. Our facility policy is to dispose of expired foods immediately. On [DATE] at 10:20 AM, emergency supply shelves showed the following expired items: honey consistency dairy beverage and jelly packets expired ,[DATE], pureed meat expired ,[DATE], sugar free jelly expired ,[DATE], regular jelly packets, rice cereal and raisin bran cereal expired ,[DATE], apple juice expired ,[DATE] and peanut butter crackers expired ,[DATE]. The facility's policy titled Sanitation and Food safety revised 2017 showed, Labeling and dating foods: To decrease the risk of food borne illness and to provide the highest quality, foods are labeled with the date received, the date opened and the date by which the item should be discarded.
F 0880 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide and implement an infection prevention and control program.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to perform hand hygiene between dirty and clean glove changes during personal care to prevent cross contamination for 2 of 3 residents (R82, R287) and failed to ensure residents clothing was free from feces for 1 of 3 residents (R12) reviewed for infection control in the sample of 18. The findings include: 1. R82's electronic face sheet printed on 3/12/20 showed R82 has [DIAGNOSES REDACTED]. R82's care plan revised 3/15/18 showed, (R82) has an activities of daily living (ADL) self-care performance deficit related to complexities of medical diagnoses. (R82) requires supervision to limited assist of 1 for personal hygiene and oral care. R82's care plan revised 12/27/19 showed, (R82) has incontinent episodes and requires staff assistance with toileting tasks. (R82) does not recognize toileting needs and has poor toileting habits. Interventions include provide perineal care and apply moisture barrier after each incontinent episode. R82's facility assessment dated [DATE] showed R82 has moderate cognitive impairment, requires 2+ staff physical assistance for personal hygiene and is incontinent of bowel and bladder. On 3/11/20 at 1:40 PM, V11 and V12 (certified nursing assistants-CNA's) were providing perineal care to R82. V11 cleaned R82's feces off her buttocks, removed her gloves and applied clean gloves with no hand hygiene in between glove changes. V12 then cleaned the feces off of the other side of R82's buttocks, removed her gloves and put clean gloves on with no hand hygiene in between glove changes. 2. R287's electronic face sheet printed on 3/12/20 showed R287 has [DIAGNOSES REDACTED]. R287's bowel and bladder history dated 3/10/20 showed R287 is always incontinent of bladder and bowel and requires total assistance of staff for incontinence care. R287's care plan dated 3/10/20 showed (R287) has an ADL self-care performance deficit related to [DIAGNOSES REDACTED]. Interventions include R287 requires extensive assistance of 2 staff members for personal hygiene. On 3/11/20 at 10:30 AM, V11 and V13 certified nursing assistants (CNA's) were providing personal care to R287. V13 cleaned feces from R287's perineal area and buttocks, took her dirty gloves on and applied clean gloves with no hand hygiene in between glove changes. V11 then cleansed feces off of the other side of R287's buttocks, removed her dirty gloves and applied clean gloves with no hand hygiene in between glove changes. On 3/12/20 at 10:23 AM, V11 CNA stated, Hand hygiene should be performed after you wash the front of the resident's perineal area and after you clean the resident's buttocks. You should also perform hand hygiene between different cares such as brushing teeth, washing face and washing the resident's body. On 3/12/20 at 9:58 AM, V2 Director of Nursing (DON) stated, Hand hygiene would be performed in between dirty and clean glove changes to prevent the spread of infection. The facility's policy titled Handwashing/Hand Hygiene revised 1/2014 showed, This facility considers hand hygiene the primary means to prevent the spread of infections .2. All personnel shall follow the Handwashing/hand hygiene procedures to help prevent the spread of infections to other personnel, residents, and visitors .5. Employees must wash their hands for at least 20 seconds using antimicrobial or non-antimicrobial soap and water under the following conditions: u. after removing gloves .When to use alcohol based hand rub .f. Before moving from a contaminated body site to a clean body site during resident care .8. The use of gloves does not replace handwashing/hand hygiene. 3. R12's Admission Record printed 3/11/20 shows he has [DIAGNOSES REDACTED]. R12's restorative care plan shows (R12) has decreased lower body dressing skills and requires prompting and cueing to ensure clean clothes are applied daily. R12's activities of daily living care plan shows he requires supervision set-up assistance for dressing, and supervision of one staff member for toileting. The facility assessment dated [DATE] shows R12 has moderate cognitive impairment, requires

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 _____	**03/12/2020**

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.

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F 0880 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 4) limited assist of one staff member for dressing and extensive assist of one staff member for toileting. On 3/10/20 at 10:28 AM, R12 was lying in bed with his eyes closed. The pair of tennis shoes on the floor next to R12's bed had visible stool on the inside and on the outside of the shoes. At 1:38 PM, R12 was lying in bed, on top of his blankets, with the soiled tennis shoes on. On 3/11/20 at 8:19 AM, R12 was lying in bed with the soiled tennis shoes on. At 2:37 PM, this surveyor went with V3 ADON (Assistant Director of Nursing) to R12's room. R12 was again lying in bed with the soiled tennis shoes on. V3 removed R12's shoes. V3 verified that it was feces on the outside and in the inside of the tennis shoes. V3 said she would expect the staff to notice the stool and take the shoes to the laundry department to be cleaned. V3 said it is important to do this for infection control. On 3/12/20 at 12:59 PM, V27 CNA (Certified Nursing Assistant) said it is important for dignity purposes and for infection control purposes to make sure the residents clothing and their shoes are clean and have no feces on them. On 3/12/20 at 1:06 PM, V10 LPN (Licensed Practical Nurse) said it is important to make sure the residents clothing and shoes are clean, with no feces on them for infection control and dignity issues. The facility's policy and procedure titled Departmental (Environmental Services)-Laundry and Linen with a revision date of January 2014 shows The purpose of this procedure is to provide a process for the safe and asceptic handling, washing, and storage of line . 1. Separate soiled and clean linen at all times .3. Consider all soiled linen to be potentially infectious. 5. All soiled linen must be placed directly into a covered laundry hamper which can contain the moisture. Place any linen saturated with blood or body fluids into a bag before placing it into the hamper .10. Shoes that become soiled and that can be laundered are taken to the laundry in a bag and washed in the facility washing machine. Shoes that can not be laundered that are soiled will be cleaned with an EPA registered germicidal agent.