STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145968	A. Building B. Wing	09/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Kewanee Care Home	144 Junior Avenue Kewanee, IL 61443

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** 49187 Based on record review and interview the facility failed to notify the physician and resident's representative promptly after a fall with an injury for one of three residents (R1) reviewed for notification of changes in condition in the sample of four. Findings include: The facility's Notification for Change in Resident Condition or Status, undated, documents Policy: The facility and/or facility staff shall promptly notify appropriate individuals (Administrator, DON (Director of Nursing), Physician, Guardian, and HCPOA (Health Care Power of Attorney) of changes in the resident's medical/mental condition and/or status. Responsibility: Administrator, Director of Nursing, Charge Nurse. Procedure: 1. The nurse supervisor/charge nurse will notify the resident's attending physician or on-call physician when there has been: b. An accident or incident involving the resident. 2. The nurse supervisor/charge nurse will notify the DON, physician, and unless otherwise instructed by the resident the resident's next of kin or representative when the resident has any of the above-mentioned situations or: a. The resident is involved in any accident or incident that results in an injury including injuries of an unknown source. R1's Wellness Event Record Late Entry dated 9/2/2024 at 10:46 AM and signed by V4 (Licensed Practical Nurse/LPN) documents, (R1) appears to have sustained an injury that was unwitnessed- or is of unknown origin. Event was first noted on 9/2/2024 at 12:00 AM. (R1). Vocal complaints of pain at the time of the event. Facial expressions (e.g., grimaces, winces, wrinkled forehead, furrowed brow, clenched teeth, or jaw) at the time of the event. Practitioner was not notified of the event at this time. Resident Responsible Party was not notified of the event at this time. Resident Interested Party was not notified of the event at this time. On 9/11/24 at 11:59 AM V11 (R1's Representative) stated, I came into the facility on [DATE] to pick (R1) up to take him on a home visit. I noticed (R1's) left wrist was swollen. I asked staff why (R1's) left wrist was swollen and no one knew. I then spoke to (V4), and she told me (R1) had a fall the day before (9/1/24) and hurt his wrist. I was not notified about (R1's) fall or (R1's) swollen wrist. I should have been notified. (continued on next page)

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.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145968	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Kewanee Care Home	144 Junior Avenue Kewanee, IL 61443

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	On 9/11/24 at 12:55 PM V4 (LPN) stated, I was told from (V10 Registered Nurse) during morning report on 9-2-24 that (R1) was complaining of pain to the left wrist and that (R1) fell on [DATE]. V8 (Certified Nursing Assistant) had not reported the fall to anyone. I went out to the dining room table to assess (R1) and noticed his left wrist was swollen. I put in an order to obtain and x-ray to (R1's) left wrist. I did not notify V12 (R1's Primary Physician) or V11 (R1's Representative) about the fall or (R1's) having a swollen wrist. On 9/11/24 at 1:00 PM V8 (Certified Nursing Assistant) stated, I found (R1) sitting in front of his recliner on the floor on 9/1/24 (unknown time). At the time (R1) stated he was leaning forward trying to pull his wheelchair closer and slid to the floor. I assisted (R1) back to the recliner. I did not report it to the nurse because I didn't realize they considered it a fall. I just thought since (R1) slid to the floor and could tell me what happened it wasn't a fall. On 9/11/24 at 2:00 PM V2 (Director of Nursing) stated, V11 (R1's Representative) and V12 (R1's Primary Physician) were not notified immediately after (R1's) fall and were not notified about (R1's) left wrist swelling. (V11) and (V12) should have been notified immediately after the fall.