Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6012587	A. BUILDING: ______ B. WING ______	C 10/03/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROSEWOOD CARE CENTER OF MOLINE	7300 34TH AVENUE MOLINE, IL 61265

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	Initial Comments Complaint IL106012 Statement of Licensure Violations	S 000		
S9999	Final Observations 300.610a) 300.1210b) 300.3240a) Section 300.610 Resident Care Policies a) The facility shall have written policies and procedures governing all services provided by the facility. The written policies and procedures shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee, and representatives of nursing and other services in the facility. The policies shall comply with the Act and this Part. The written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, documented by written, signed and dated minutes of the meeting. Section 300.1210 General Requirements for Nursing and Personal Care b) The facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive resident care plan. Adequate and properly supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident. Restorative measures shall include, at a minimum, the following procedures:	S9999	Attachment A Statement of Licensure Violations	

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Section 300.3240 Abuse and Neglect
a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a residentThese requirements were not met as evidenced by:

Based on observation, interview and record review the facility failed to ensure four residents (R4, R5, R7, R8) of four residents reviewed for mental and verbal abuse remained free from such abuse.

This failure caused residual emotional distress to R4 and R5.

Findings include:

Facility Policy/Abuse, Neglect, Mistreatment and Misappropriation of Resident Property dated 2018 indicates:
Residents will not be subjected to abuse by anyone.

- Verbal Abuse is defined as the use of oral, written or gestured language that willfully includes disparaging and derogatory terms to residents or within their hearing distance - regardless of their age, ability to comprehend or disability.
- Mental abuse includes but not limited to humiliation.
- It is the policy of this center that each resident will be free from "abuse." Additionally, residents will be protected from abuse, neglect, and harm while they are residing at the center. No abuse or harm of any type will be tolerated.

1. POS (Physician Order Sheet) dated 9/2018 indicates R4 was admitted to the facility 10/9/16 with diagnoses that include Urine Retention with

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Indwelling Urinary Catheter.

MDS/BIMS (Minimum Data Set/Brief Interview for Mental Status) dated 7/30/18 indicates R1 scores 15/15, is alert and cognitively intact. MDS indicates R1 has an indwelling urinary catheter.

On 9/28/18 at 10:55am R4 stated that (on Monday 9/24/18) an "Agency CNA (V10)" was getting her into the shower chair and her catheter was hooked to the mechanical lift. R4 stated that the catheter pulled and hurt and she told V10 that she had a catheter. R4 stated that V10 responded by stating "I've been an Aide for 10 years - I know you have a catheter." R4 then told V10 that she didn't care how long she had been an Aide, it hurt. R4 stated that the CNA (Certified Nursing Assistant) responded "Well, I don't care how long you haven't walked." R4 stated that the CNA continued on with the shower and it was the "worst shower she ever had." R4 stated that she told V2, DON "yesterday (9/27/18)" about V10. R4 stated that it made her angry and that she felt "worthless" by the way she was treated by V10. R4 started crying part way through recalling the incident and continued tearful throughout the interview.

Preliminary Incident Investigation dated 9/27/18 and Final Investigation dated 10/2/18 indicate on the morning of 9/24/18 V10, CNA was transferring R4 with a mechanical lift and when V10 started moving the lift away from R4, R4 felt pain and quickly reminded V10 that she had a catheter and that V10 forgot to move the bag. V10 responded by stating she had been a CNA for 10 years. R4 then told V10 she didn't care how many years she had been a CNA, to which V10 replied "I don't care how long it's been that you haven't walked."

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Preliminary Investigation indicates that R4 "cried when reported to (V2) as her feelings are hurt." Both Investigations indicate V10 had not worked at the facility since 9/24/18 and was terminated on 9/27/18 and not allowed to return to the facility.

On 10/2/18 at 3:00pm V2, DON stated that R4 is an emotional person and was tearful recalling events that took place (9/24/18).

On 10/3/18 at 12:50pm V14, Social Service Director stated that R4 is a quiet person, pleasant, sensitive and emotional and her feelings are hurt easily. V14 stated that she followed up with R4 the day after it was reported but not since.
Care Plan Addendum dated 10/3/18 indicates R4 is at risk for residual effects related to emotional distress.

2. POS dated 9/2018 indicates R5 is 65 years old and was admitted to the facility 12/14/17 with diagnoses that include Diabetes Mellitus, End Stage Renal Disease/Dialysis Dependent and Heart Failure.

Quarterly MDS/BIMS dated 9/24/18 indicates R5 scores 12/15; requires extensive assist of two staff with transfers and toileting.

On 9/28/18 at 11:15am R5 stated that she had a "situation" yesterday with staff and she reported it to a nurse. R5 stated that she came back from dialysis (on 9/27/18), felt weak and the CNA (V11) wouldn't help her go to the bathroom. R5 stated that she could hardly stand up and V11 made her feel bad because she couldn't do more to help. R5 stated that V11 just left her sitting on the side of the bed and never came back. V11 stated that she was upset and just laid herself back on the

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bed because she could hardly sit up.

Final Investigation Report dated 10/2/18 indicates R5 stated that V11 left her alone on the side of the bed when R5 needed assistance. Report indicates R5 had been to dialysis earlier that day and was weak and tired. R5 stated that V11 tried to transfer her but because she was weak and couldn't help much, V11 became frustrated and just left R5 and walked out of the room.
Report indicates another CNA and V13, LPN (Licensed Practical Nurse) found R5 lying perpendicular on her bed, "crying, very upset" and needing assistance. Report indicates V11's statement admitted that she "just left" R5 and expressed that she felt R5 was just trying to be "difficult" and not helping.
V11 written statement dated 9/27/18 indicates V11 attempted to get R5 up three times from the bed to the chair and after the third time she told R5 "When you're ready to help me, I'll help you."
Investigation indicates R5's story very consistent with all interviews and R5 "tearful upon recall."
Investigation indicates V11 was terminated from employment on 9/27/18.

On 10/3/18 at 11:10am V13, LPN stated that he had just come out of another residents room on (9/27/18) and observed R5 lying perpendicular across the bed, on approach saw R5 was crying, upset and asking for help. V13 stated that R5 told him that V11 had been assisting her, became upset and left her. V13 stated that R5 had dialysis that day and requires more assistance due to being weak. V13 stated that V11 just left R5 sitting on the bed, didn't go to find any other staff for help. V13 stated that he and another CNA helped get R5 positioned correctly in bed, attended to her needs then immediately removed V11 from resident care until V1, Administrator

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arrived. V13 stated that R5 seemed upset and withdrawn the remainder of the evening. V13 stated that R5 is an accurate historian and fully oriented.

On 10/3/18 at 1pm V14, Social Service Director stated that she talked to R5 the day after the incident occurred and that R5 became tearful during the conversation when recalling the events.
Care Plan Addendum dated 10/3/18 indicates R5 at risk for residual effects to emotional distress.

3. Report of Serious Incident/Accident/Final Report dated 7/19/18 indicates:
"Neglect was evidenced by the refusal to perform care for residents and inappropriate remarks made by Agency CNA (V12)."
Report indicates (on 7/15/18) V12 responded to resident call lights, walked into their room and shut off the call light and refused to care for the resident. Investigation indicates V12 was terminated on 7/15/18 and not allowed back to the facility.

On 10/2/18 at 11:15am V6, CNA stated that (on 7/15/18) she assisted R6 onto the toilet and was then going to assist R7 off the toilet because she knew her call light was on. On the way to help R7, she saw R7's light was off and saw V12 coming from R7's room. V6 asked V12 if she had helped R7 and V12 responded no, she just turned off the light and said "she can sit." V6 stated that V12 stated "I can't stand her", referring to R6 and R7 as V12 walked away.
V6 stated that she immediately went to R7 to get her off the toilet.

4. On 10/2/18 at 11:15 am V6, CNA stated that she asked V12 to assist her in incontinent care

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for R8 who had a bowel movement. V6 stated that V12 was making remarks out loud while changing R8 such as" You smell. That smells awful. I can't stand it." V6 stated that R6 wasn't saying anything, but had a sad look on her face. V6 stated that she knew it was abuse and told a manager who immediately called V1, Administrator and V12 was removed from the facility.

Quarterly MDS/BIMS dated 9/17/18 indicates R8 is severely cognitively impaired, is totally dependent on staff for toileting/incontinent care.

R6 and R7 were seen in the hallway on 9/28/18. Neither R6 or R7 could recall events that occurred in July.
On 9/28/18 at 2:15pm R8 was seen in her room. R8 did make eye contact, however did not answer questions or engage in conversation.

On 10/3/18 at 12:55pm V14, Social Service Director stated that R8 cannot converse and can barely answer questions. V14 stated that she was not aware until recently about the incident that took place (7/15/18). V14 stated that she would have followed up with R8 if she had known what happened. V14 stated she should be notified of residents that make allegations of abuse or incidents when residents are abused.

(B)