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
	IL6014666	A. BUILDING: _____ B. WING _____	C 09/07/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROSEWOOD CARE CENTER OF ST CHARLES	850 DUNHAM RD ST CHARLES, IL 60174

(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 Complant Investigation # 1775117/ IL 96387 1775201/ IL 96489	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.1210 a) 300.1210 d) 5) 300.3240 a) Section 300.1210 General Requirements for Nursing and Personal Care a) Comprehensive Resident Care Plan. A facility, with the participation of the resident and the resident's guardian or representative, as applicable, must develop and implement a comprehensive care plan for each resident that includes measurable objectives and timetables to meet the resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment, which allow the resident to attain or maintain the highest practicable level of independent functioning, and provide for discharge planning to the least restrictive setting based on the resident's care needs. The assessment shall be developed with the active participation of the resident and the resident's guardian or representative, as applicable. (Section 3-202.2a of the Act) d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour,	S9999	Attachment A Statement of Licensure Violations	

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S9999	Continued From page 1 seven-day-a-week basis: 5) A regular program to prevent and treat pressure sores, heat rashes or other skin breakdown shall be practiced on a 24-hour, seven-day-a-week basis so that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that the pressure sores were unavoidable. A resident having pressure sores shall receive treatment and services to promote healing, prevent infection, and prevent new pressure sores from developing. Section 300.3240 Abuse and Neglect a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. (A, B) (Section 2-107 of the Act) These requirements are not met as evidenced by: Based on observation, interview, and record review the facility failed to choose the correct size of a medical device (cervical collar) to prevent the development of pressure ulcers on R4's bilateral ears, back of the head (occipital area) and chin. Failed to develop and implement a plan of care to promote healing and prevent the development of additional wounds from developing. This applies to 1 of 1 residents (R4) reviewed for medical device related injury. R4 developed multiple stage 3 pressure ulcers as a result of a tight fitting rigid cervical collar. The findings include:	S9999		

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S9999	Continued From page 2 The wound documentation report showed that on August 1, 2017 a wound was identified on R 4's posterior scalp measured at 2.8 cm X 3.1 cm X0.3 cm with 80% slough. On September 1, 2017 at 1:03 PM via phone interview, E 8 (Treatment Nurse) explained R 4 developed a Stage 3 on both ears and a wound at the back of the head (occipital area). E 8 explained that the occipital wound started as a hematoma - purple in color and on August 1, 2017, this wound opened up due to pressure from the neck collar. E 8 stated, "Because the collar is always on." E 8 also described the wounds are located at the edge of the collar. This occipital wound was initially observed with 80% slough which worsened and became necrotic." On August 21, 2017 a clinical note from Z 2 (Hospice Doctor) showed that on June 26, 2017 R 4 sustained a fall during transfer via a (total) mechanical lift and fell backwards hitting the back of her head. R 4 was sent to Emergency Room for evaluation and treatment. R 4 was diagnosed with subdural hematoma, and closed non-displaced fracture of the second cervical vertebrae (C 2 fracture). A soft cervical collar was placed on R 4 and was transferred back to the facility. This note reads, "Since then R 4 has limited mobility. Now has (1) two wounds on the head ...and (2) on bilateral ears surrounding the area of the cervical collar ...and (3) a new area located in the midline on her chin where cervical collar lies. The cervical collar was noted to be a stiff-rigid cervical collar not the same collar that she was discharged from Emergency Room with ... On September 1, 2017 at 3:20 PM, via phone interview Z 2 (Hospice doctor) explained, "When	S9999		

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S9999	Continued From page 3 R 4 was discharged from the hospital they (hospital) put a soft perfectly fitting neck collar on R4. R 4 has a short neck and the collar that they put on her at the hospital is just the right fit for her. The facility decided to change it and put a very hard and very rigid collar on R4. I am not surprised that she (R 4) developed these wounds. She developed 2 wounds at the back of her head, 2 on her ears and one at the bottom of her chin that the facility does not even know. These wounds are all from that rigid collar. I do not understand how someone could say it is not from the collar because the wounds are located on top of the collar. I told them to put the soft collar back on, if they had not changed the soft to a hard neck collar she would not have developed these wounds. On September 1, 2017 at 3:40 PM, via phone interview Z 3 (Wound Doctor) stated, "She (R4) was given an ancient rigid collar, anatomically not the right fit for her. Yes, the wounds on her ears were due to the neck collar." At 4:45 PM, via phone interview Z 4 (Physical Therapy Director) explained that on June 26, 2017, R 4 was admitted from the hospital with a "cheap" foam collar, so the ancillary staff ordered a different kind of collar which was put on her on July 7, 2017. R4 was not evaluated by Physical Therapist because she is under hospice care. On July 25, 2017, E 2 (Director of Nursing) said it was rubbing on the bottom of her ears. The collar was too high for her. Her neck is too short." R 4's wound care specialist initial evaluation dated July 18, 2017 showed R 4 developed a Stage 3 on the right and left ear. The notes showed the left ear wound, a Stage 3 of least 2 days duration (no measurement provided), the	S9999		

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S9999	Continued From page 4 right ear a Stage 3 when initially found, a date provided but documented less than 9 days, with 20 % necrotic tissue. Z 3 (Wound doctor) additional information showed: R 4 is fairly small and has an XL sized collar, which I believe at this time is too large as a result of her ears being poorly seated, she developed 2 pressure injuries on her ears. The nursing wound documentation /measurement for these areas (right and left ear) was not provided as requested. On September 1, 2017 at 1:03 PM via phone interview, E 8 (Treatment Nurse) explained that the facility has no comprehensive wound assessment for R 4 and E 8 also stated that she does not write the care plan. There was no care plan developed for R 4's wounds. (B) 300.610 a) 300.1210 c) 300.1210 d) 6) 300.3240 a) 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	S9999		

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S9999	Continued From page 5 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 c) Each direct care-giving staff shall review and be knowledgeable about his or her residents' respective resident care plan. d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour, seven-day-a-week basis: 6) All necessary precautions shall be taken to assure that the residents' environment remains as free of accident hazards as possible. All nursing personnel shall evaluate residents to see that each resident receives adequate supervision and assistance to prevent accidents. Section 300.3240 Abuse and Neglect a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. (A, B) (Section 2-107 of the Act) These requirements were not met as evidenced by: Based on observation, interview and record review, the facility staff did not transfer R4 safely. One staff transferred R4 using a mechanical sling lift instead of two people as care planned. This	S9999		

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S9999	Continued From page 6 failure resulted in R4 sustaining a fractured second cervical vertebra and a subdural hematoma. This applies to 1 of 6 residents reviewed for falls and transfers. The finding includes: 1) The face sheet for R4 documents the date of admission as 5/4/14. R4's care plan dated 5/8/17 shows R4 is dependent on the staff for all transfers using a sling mechanical lift for all bed to chair transfers. The care plans states transfers will be completed by a physical assist of two at all times. R4's MDS (minimum data set) of 6/22/17 shows R4 requires two people physical assistance with bed mobility and transfers. The hospital record for R4 dated 6/26/17 states R4 was in a lift when she fell out backward onto her head. There is swelling to the back of her head. The diagnosis list subdural hematoma and neck fracture - closed nondisplaced fracture of second cervical vertebra. A cervical collar was in place. The facility incident investigation report of 6/26/17 states R4 is under hospice care, alert and oriented to person only, requires total assist for her activities of daily living including bed mobility and transfers and is non-ambulatory. R4 was being transferred from her bed to chair via lift by E9 CNA (Certified Nurse Aide) when R4 slipped out of the sling onto the floor. The nursing assessment showed swelling on top right side of the resident's head accompanied with pain. R4 was transferred to the emergency room for evaluation.	S9999		

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S9999	Continued From page 7 An in-service education meeting attendance sheet documents on 6/26/17 and 6/27/17 thirteen CNA's and one registered nurse were trained on the use of sling and sit to stand lifts requires two people at all times. The facility policy dated 3/31/08 Total Resident Transfers using Mechanical Lifts require a minimum of two trained staff members to complete a resident transfer. On 8/25/17, 8/29/17, and 8/31/17 R4 was observed to have a soft cervical collar on. On 8/30/17 at 12:15 PM R4 was in the dining room wearing a ridged collar calling out and moaning "ouch, hurts, ooh." Staff tried to adjust this collar to make R4 more comfortable. On 8/31/17 E8 wound nurse said she got an order to replace the ridged collar with the soft one until a new collar is obtained. On 8/30/17 at 12:55 PM E8 RN would nurse said R4 had a subdural hematoma from the fall of 6/26/17 which opened up on 8/1/17. This wound measured 2.8 cm long, 3.1 cm wide and 0.3 depth. The weekly wound documentation shows the wound continues with a moderate amount of serous exudate. Measurements on 8/29/17 are length 1.5cm, width 5.5 cm, depth 0.3 cm. E8 said the wound probably opened up from laying on the hematoma. On 8/31/17 at 10:10 AM E9 CNA said she did transfer R4 by herself when she slid out of the sling and hit the floor. E9 said she knew she should have had two people and has since attended in-service education along with all CNA's regarding the need for two people at all times for mechanical lift transfers. E9 said R4 has since gotten a bigger sling that fits her better. The	S9999		

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S9999	Continued From page 8 sling used on 6/26/17 may have been too small and the material was slippery. On 8/31/17 at 2:20 PM Z1 (R4' primary care physician) said per telephone interview, that the facility staff should have followed the policy to use two people for the transfer. R4 is a bigger person and is more likely to fall with one person using the lift. (A)	S9999		