STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6012074	A. BUILDING: _____ B. WING _____	C 12/14/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROSEWOOD CARE CENTER OF ALTON	3490 HUMBERT ROAD ALTON, IL 62002

(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 Investigation 1747248/IL98796	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.1210b) 300.1210c) 300.1210d)6) 300.3240a) 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: 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	S9999	**Attachment A** **Statement of Licensure Violations**	

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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.

These requirements were not met as evidenced by:

Based on record review and interview, the facility failed to ensure safety measures were in place for 1 of 4 residents (R2) reviewed for falls in the sample of 4. This resulted in R2's fall sustaining a subdural hematoma.

Findings include:

R2's undated Face Sheet documents admission to the facility on 12/3/17 with admitting diagnoses: Cerebral Vascular Accident, (CVA), Atrial Fibrillation (A-Fib), Amyotrophic Sclerosis (ALS), and Hypertension.

Physician's Order Sheet, dated December 2017, documents R2 is prescribed the anticoagulants, Apixaban (Eliquis) 5 mg (milligrams) twice daily and Aspirin 81 mg daily.

R2's Fall Risk Assessment, dated 12/4/17, determined R2 at risk for falls. The Fall Risk Assessment documents Fall Prevention Measures were initiated on 12/3/17 which include: "Keep call light within reach, Remind resident to call for assistance, Monitor frequently, Access for

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proper fitting w/c (wheelchair), Proper fitting leg rests." The Fall Risk Assessment documents, after a fall on 12/4/17, additional measures were initiated: "Use low bed, floor mat surrounding bed."

Narrative Nurse's Progress Notes, dated 12/4/17 and untimed, documents, "(R2) found out of bed on floor during 2:40 P hall check. Resident laying in bed resting prior to being found on floor. He was laying on left side. Denies pain and denies hitting head." Narrative Nurse's Progress Notes, dated 12/5/17 at 3:30 AM by V5, Registered Nurse (RN), document, "Vital sign monitoring as follow up for new admit et (and) found on floor. Vital signs show B/P (Blood Pressure) elevated at midnight. Resident restless et attempting to get out of bed. Placed in w/c et brought to nurse's station. Denies pain or discomfort. States 'Yes' when asked if he was having trouble sleeping. B/P improved et restless decreased after sitting up." Narrative Nurse's Progress Notes, dated 12/6/17 at 1:10 AM by V5, document, "Called to residents room by CNA (Certified Nurses Assistant). Resident found lying partially on Rt (Right) side and partially on stomach with active bleeding from a Rt forehead laceration. (V4, Physician) and spouse updated. (R2) to hospital for eval (evaluation)."

Hospital report, dated 12/6/17, documents, "CT (Computerized Tomography) Head without Contrast Findings: There is an acute-on-chronic right frontal/parietal subdural hematoma with acute blood visible at both the inferior aspects of the right frontal region and at the lateral aspect of the more superior right frontal region and at the lateral aspect of the more superior right parietal region."

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Incident/Accident Report, dated 12/6/17 at 1:10 AM by V5, documents, "This writer entered room to find resident on floor partially on stomach and partially on Rt side. Resident struck his Rt forehead and face on floor. Large Y shaped laceration with active bleeding noted. Hematoma to Rt cheek."

R2's Incident investigation for 12/6/17 at 1:10 AM, V2, Director of Nurses (DON), documents, "Commentary: Pt (Patient) admitted to hospital. Staff education to remain physically with patient when bed is in high/normal position-mats had been picked up from floor for transfer out of bed." "Environment: bed in standard position Change in Mental Status/Confusion: Restless."

Incident investigation for 12/6/17 at 1:10 AM, V7, CNA, documented, "Re (Regarding): (R2) Dec (December) 6, 2017 On Dec 6, 2017 early AM hours, (R2) became agitated and restless. Using his right hand pounding on rail and yelling, (R2) was able to use rail to sit on side of bed. Bed was to the floor with mats on each side. To the best of my knowledge since I was unable to understand him verbally, I decided to get him up in his wheelchair to which he was able to partially communicate he agreed by saying OK. I then asked co-worker CNA to come and help get him up after I got him ready. I changed him with a new pad, underwear, pants, and shirt while folding and removing sheets under him that were wet. After I had him dressed and ready while I raised bed to transfer position I removed mat and folded it from right side of bed and prepared wheelchair at end of bed for his transfer. He was laying more toward the bottom of the bed as he had previously in the night sat up on the side of the bed by himself. I told him 'Hold on were going to get you up in just a minute' (R2) said 'OK'. I

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walked to doorway to look toward desk for the coworker. Upon standing in the doorway looking toward desk, (R2) had fallen off the side of the bed as I turned around and (R2) was on the floor where he had hit his head. I yelled for help and coworkers were there in room immediately."

Incident investigation for 12/6/17 at 1:10 AM, V6, CNA, documented, "(V7) asked me to help her with (R2) at the time I was busy at the time she asked. (V7) was standing in the doorway of the (R2's) room as I was walking down the hall to assist I heard a loud noise and (R2) was on floor. The bed was up high enough to change the linen and the mat was up against wall."

Incident investigation for 12/6/17 at 1:10 AM, V5 documented, "This nurse was on hold on the Pharmerica. I observed (V7) walk into (R2's) room. (V7) stuck her head out of the door as (V6, CNA) was walking down the hall towards (R2's) room. (V6) suddenly began running and stated, 'He's fallen.' When this nurse entered room, resident found lying on stomach et partially on Rt side. Active bleed noted from forehead laceration."

On 12/14/17 at 10:15 AM, V5 stated, "I did notice the mat was folded up and next to the wall at the head of the bed and the bed was really high up. I'm short, but the bed was really high up."

On 12/14/17 at 9:40 AM, V2 stated, "I would have expected, (V7) to put the bed down in the lowest position and replace the mat next to the bed before walking away from the bed."

On 12/14/17 at 9:40 AM, V4, R2's Physician, stated the head injury was due to the fall and the subdural hematoma could be due to the height of

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the bed and the mat being not placed next to the bed. V4 stated, "Yes, the bed should have been in the lowest position and the mat should have been next to the bed before walking away from the bed."

On 12/13/17 at 2:03 PM, V7, stated, "It all happened so fast, I thought when he said 'Ok,' he would wait for me to get him out of bed. I should have lowered the bed and put the mat back in place before I left him."

The Facility's Fall Risk Assessments Policy, dated 9/2003, documents, "When significant potential for falls is noted via the assessments, appropriated fall prevention measures will be implemented."

(A)