

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6012074	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED C 04/26/2018
NAME OF PROVIDER OR SUPPLIER ROSEWOOD CARE CENTER OF ALTON			STREET ADDRESS, CITY, STATE, ZIP CODE 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 INITIAL COMMENTS Complaint #1842518/IL101955	S 000			
S9999	Final Observations Statement of Licensure Violations: 300.1210b) 300.1210d)6) 300.1220b)3) 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: 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	S9999			

Attachment A
Statement of Licensure Violations

Illinois Department of Public Health

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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S9999	Continued From page 1 and assistance to prevent accidents. Section 300.1220 Supervision of Nursing Services b) The DON shall supervise and oversee the nursing services of the facility, including: 3) Developing an up-to-date resident care plan for each resident based on the resident's comprehensive assessment, individual needs and goals to be accomplished, physician's orders, and personal care and nursing needs. Personnel, representing other services such as nursing, activities, dietary, and such other modalities as are ordered by the physician, shall be involved in the preparation of the resident care plan. The plan shall be in writing and shall be reviewed and modified in keeping with the care needed as indicated by the resident's condition. The plan shall be reviewed at least every three months. 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 provide supervision to to prevent falls for 1 of 3 residents (R2) reviewed for falls in the sample of 7. Findings include: R2's Health Record, Face Sheet, dated 4/26/18,	S9999			

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S9999	Continued From page 2 documents R2 was admitted to the facility on 12/31/16 with diagnoses of: "Fracture of right pubis, fracture of right ilium, fracture of sacrum, weakness, dementia without behavioral disturbances, difficulty in walking, and muscle weakness." R2's Minimum Data Set (MDS), dated 1/5/18, documents R2's Functional Status with transfers as needing extensive assistance of one person physical assist and walking in corridor as needing limited assistance with one person physical. The MDS also documents R2's Brief Interview for Mental Status (BIMS) score as 7, severely impaired cognition. R2's Care Plan Report for Problem At Risk for Falls, status Active (Current) with goal date 6/26/18, documents, History of falls within 6 months of admission, has impaired vision, fatigues quickly, had weakness and unsteady gait, frequently incontinent. The Care Plan also documents Interventions to include: "Low bed with raised edge mattress with mats surrounding for fall prevention related to unsafe attempts to transfer or ambulate without assistance and rolls out of bed"; "Monitor and provide needs, such as hunger, pain, toileting"; "Offer and assist with position changes if restless"; "Offer warm shower during periods of restlessness"; "Resident is under the Watchful Eye Program. Watchful eye should be placed on back of residents wheelchair and on resident's name plate. Resident should not be left alone in room while up in wheelchair. Resident should be kept in highly visible area"; "Monitor by keeping guest in visible areas as necessary and possible. (sit near nurses station, bring to activity programs, etc)." The Watchful Eye Program, undated, documents,	S9999			

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S9999	Continued From page 3 "Residents that are at a fall risk and deemed unsafe to be left alone, unsupervised, while up in their wheelchairs will be placed on the Watchful Eye Program. These residents are to be in common areas and in line of sight supervision while up in wheelchair. Residents identified to be designated for the Watchful Eye Program will be made known to staff by a placard attached to their Wheel chair with a bright green Watchful Eye." R2's Incident/Accident Report, dated 1/2/18 at 1:45 AM, documents: "Resident has been sitting in recliner in DR (Dining Room)-while everyone had been away from desk-Resident got up and ambulated down 400 Hall and fell-hitting head on something ,was in hallway, sitting on buttocks-Did neuros (Neurological checks) WNL (Within Normal Limits) noted laceration to top of head bleeding." The Report also documents R2 taken to the local hospital Emergency Room. R2's Incident Investigation for incident 1/2/18, dated 1/4/18, documents CT (computerized axial tomography) of spine and brain negative. It also documents, "Guardian contacted et (and) stated she would reach out to sitter service to (increase) safety for resident to prevent falls." On 4/26/18 at 8:55 AM, V2, Director of Nursing (DON), stated, "(R2) was on the Watchful Eye Program when he fell on 1/2/18. The staff had put him in the recliner in the dining room because he kept trying to get out of bed and didn't want to go back to sleep. The staff did step away from the desk and yes, (R2) did fall. (R2) was placed on the Watchful Eye Program when it was instituted in October or November of 2017. The Watchful Eye Program continues to be in effect for (R2) even though he has a 24 hour care	S9999			

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