

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6014633	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 06/28/2018
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NAME OF PROVIDER OR SUPPLIER ROSEWOOD CARE CENTER OF INVERNESS	STREET ADDRESS, CITY, STATE, ZIP CODE 1800 COLONIAL PARKWAY INVERNESS, IL 60067
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S 000	Initial Comments Complaint Survey 1893749/IL103267 Statement of Licensure Violations	S 000		
S9999	Final Observations Licensure 1 of 2 300.1210b) 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: 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 interview and record review, the facility failed to prevent an injury of unknown origin for one resident (R1) of four residents reviewed for abuse in a total sample of four residents. This failure resulted in R1 sustaining a fractured wrist requiring medical attention.	S9999		

Attachment A
Statement of Licensure Violations

Illinois Department of Public Health

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

TITLE

(X6) DATE

07/19/18

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S9999	Continued From page 1 Findings Include; According to the facesheet, R1 is an 84 year old resident admitted to the facility on 10/14/16, with diagnoses that include, but are not limited to, dementia, major depressive disorder, contracture right and left hands, history of falls and dysphagia. Interview on 6/22/18 at 1:30 PM V4 MD (Medical Doctor) stated R1 had an impacted fracture of the wrist. This type of fracture is almost always from arms stretched out to break a fall. I have no idea how the fracture happened, R1 is bed bound. R1's hands are not contracted, he/she just holds them that way. I would have never ordered an x-ray, if I thought there was a fracture, I would have sent R1 directly to the hospital. I was very surprised about the fracture. On 6/22/18 at 11:00 AM V5 V5 CNA (Certified Nursing Assistant) stated R1 is always a two person assist, and a mechanical lift, total dependence. R1 doesn't move her hands, not combative. I noticed swollen and purple left arm first thing in the morning around 7:00 AM on 5/23/18 . I called for the nurse before I did anything. I wasn't here the day before (5/22/18), so I didn't know if something had happened on my day off. It (bruise) wasn't there the last day I worked 5/21/18. The MDS (Minimum Data Set) dated 3/21/18 documents in section C Brief Interview for Mental Status (BIMS) , R1 has severely impaired cognition. Section G Activities of Daily Living Assistance documents R1 is total dependence two person physical assist for bed mobility, how a person moves to and from lying position, turns side to side, and positions body while in bed or	S9999			

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S9999	Continued From page 2 alternate sleep furniture, also total dependence with a two person assist for transfer, how a resident moves between surfaces including to or from bed, chair, wheelchair, standing position. Section F documents R1 is always incontinent for bowel and bladder. The facility Report of Injury for R1, incident date 5/24/18 documents; On 5/23/18 CNA reported to nurse that resident's left arm has some bruising and appears swollen. When nurse assessed resident, noted left hand with bruise and swelling with pain noted when touched. Resident with limited range of motion on both upper extremities and with contractures to both hands prior to incident, MD was notified with order to apply cold compress and to do left hand x-ray. POA (Power of Attorney) notified. Final Investigation: Nurses and CNAs that took care of resident the last 3 days were interviewed. Resident requires extensive assistance with ADLs (Activities of Daily Living). He/she and swelling on has contractures/stiffness on both upper extremities. Staff stated that they did not notice any bruising and swelling, resident slept well and CNA did not notice pain. Then, on 5/23/18 when CNA was going to get up resident, noted bruising and swelling on resident's left arm. CNA reported this to nurse immediately, did not proceed with getting R1 up until resident was seen by nurse. Resident seen by Orth (Orthopedic) MD on 5/25/18. Findings was left closed radius fracture. Resident was unable to say what happened. Per staff, resident tries to grab or hold on to something when they give care or when they are transferring with the mechanical lift. Based on investigation and interviews conducted, it is possible that resident may have accidentally bumped her wrist on the side rail when being turned to sides during incontinence care or in the arm of the geri chair	S9999			

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S9999	Continued From page 3 when they got R1 up. The X-ray report dated 5/24/18 for R1 documents; Impression: Acute impacted fracture of the distal end of the radius and avulsion fracture of the ulna side process. Positive ulnar variance. On 6/26/18 at 10:00 AM V2 DON stated that we do not know what happened to R1, how he/she got the injury. R1 cannot say. R1 is a extensive total dependence assist with two staff and a mechanical lift for transfers. I did this incident investigation and wrote the report. I interviewed all staff who cared for R1 and was unable to find out what happened. Review of R1's Treatment Record documents on 5/18 resident's skin is warm, dry to touch, no skin breakdown noted, no injury noted, fair skin integrity. (B) Licensure 2 of 2 300.610a) 300.1210b)c)d)6) 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	S9999			

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S9999	Continued From page 4 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: 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. These requirements were not met as evidenced by: Based on observation, interview and record review, the facility failed to provide a resident with	S9999			

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S9999	Continued From page 5 two person assistance during turning/repositioning to prevent a resident injury for one resident (R1). The facility also failed to follow their Transfer Policy in not locking wheelchair brakes for one resident (R4). These failures affect 2 of 4 residents (R1, R4 reviewed for accidents and incidents in a total sample of four residents. As a result, R1 sustaining a head laceration which required a hospital visit and head sutures. Findings Include: According to the facesheet, R1 is an 84 year old resident admitted to the facility on 10/14/16, with diagnoses that include, but are not limited to, dementia, major depressive disorder, contracture right and left hands, history of falls and dysphagia. The MDS (Minimum Data Set) dated 3/21/18 documents in section C Brief Interview for Mental Status (BIMS) , R1 has severely impaired cognition. Section G Activities of Daily Living Assistance documents R1 as an extensive two person physical assist for bed mobility, how a person moves to and from lying position, turns side to side, and positions body while in bed or alternate sleep furniture. Section F documents R1 is always incontinent for bowel and bladder. The Incident Report dated 6/2/18 for R1 documents at 1:10 AM CNA (Certified Nurse's Assistant) called this writer's attention to come to resident's room. Noted resident (R1) was bleeding on the forehead/face. When examined, resident sustained a 4.5 cm (centimeter) vertical laceration to mid forehead with a 0.2 cm depth. CNA said he/she hit his/her head against the side	S9999			

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S9999	Continued From page 6 rail while CNA was turning/repositioning the resident. The written statement from V3 CNA in the incident report documents; on my first round I was going to change R1. When I was rolling him/her inwards to straighten the diaper, his/her legs fell off the bed, I pushed her legs back on the bed when moving pt (patient) his/her arm moved too far when rolling back which caused her head to slam into the rail. The statement is signed by V3. The Report of Injury, Date of Incident 6/2/18 written by V2 DON (Director of Nursing) documents, R1 is an 84 year old long term resident of this facility. R1 is alert but confused and disoriented. R1 requires extensive assistance with her ADL's. (Activities of Daily Living). On 6/2/18 at around 1:10 AM when CNA (V3) turned resident to the side to provide incontinence care, resident's weight shifted, and R1 accidentally bumped his/her head on the side rail, causing a laceration on the forehead with minimal bleeding. No alteration in level of consciousness. Pressure dressing applied, bleeding controlled. No manifestation of pain or discomfort. MD (Medical Doctor) notified with order to send resident to local hospital for evaluation and treatment. POA (Power of Attorney) notified. Resident returned from hospital with 7 sutures intact. Interview on 6/22/18 at 10:15 AM V2 DON stated, "The CNA (V3) works 11-7 shift. V3 was fired because of this incident (R1). V3 did the incontinence care himself. It is a two person assist for R1, that's why V3 was fired. On 6/22/18 at 11:00 AM V5 CNA stated that R1 is always a two person assist, total dependence.	S9999			

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S9999	Continued From page 7 He/she doesn't move her hands, not combative. V3's personal recorded documents, V3 was terminated on 6/4 18 for not following protocol resulting in resident injury. The resident (R1) supposed to have a two person assist with transfer. R1's Care Plan dated 6/8/18, goal date 7/10/18 documents; R1 has self-care deficits and requires assistance in turning/repositioning in bed, toileting needs, dressing, eating, personal hygiene, locomotion on and off unit and bathing. He/she is totally dependent on staff in transfer due to Dementia, Contractures of right and left hands. Goals; R1 will be turned/repositioned with the assistance of 2 people. R4 is a 78 year old resident admitted to the facility on 3/17/18 with an admitting diagnosis of unspecified fracture of unspecified femur, with additional diagnoses of, but not limited to, muscle weakness, and difficulty working. R4's MDS dated 5/12/18 documents in section C Brief Interview for Mental Status (BIMS) 13 out of 15. Section G documents R4 requires an extensive two person assist with transfers. On 6/27/18 at 11:30 AM V6 CNA and V7 RN (Registered Nurse) transferred R4 from a wheelchair to a weight chair. V7 applied a gait belt around R4's upper waist area. V6 locked the left wheelchair brake but did not lock the right wheelchair brake during transfer for R4 from the wheelchair to the weight chair. V6 and V7 transferred R4 holding his/her arms and the gait belt. During the transfer the wheelchair was moving. V6 and V7 sat R4 in the weight chair, and weighed the resident. V6 locked the right	S9999			

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S9999	Continued From page 8 wheelchair brake before transferring R4 back to the wheelchair. V6 and V7 both stated that the right wheelchair brake was not locked. V7 stated the wheelchair should be locked, if not, the resident could fall. R4 stated, "The move back to the wheelchair went much more smoothly than the first move." On 6/27/18 at 12:20 V8 Nurse Consultant stated, "The wheelchair should always be locked during transfer." The facility policy titled, Moving a patient from bed to a wheelchair, documents 3. Put the brakes on and move the foot rest out of the way. (C)	S9999		