

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6008098	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 06/12/2018
NAME OF PROVIDER OR SUPPLIER ROCHELLE GARDENS CARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 1021 CARON ROAD ROCHELLE, IL 61068		
(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 Annual Licensure and Certification Survey	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.690 300.1210b) 300.1210d)6) 300.1220b)3) 300.3240a) Section 300.690 Incidents and Accidents a) The facility shall maintain a file of all written reports of each incident and accident affecting a resident that is not the expected outcome of a resident's condition or disease process. A descriptive summary of each incident or accident affecting a resident shall also be recorded in the progress notes or nurse's notes of that resident. 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	S9999		

Attachment A
Statement of Licensure Violations

Illinois Department of Public Health

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

TITLE

(X6) DATE

07/13/18

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S9999	Continued From page 1 care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident. 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 300.1220 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	S9999			

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S9999	Continued From page 2 a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. (Section 2-107 of the Act) These requirements were not met as evidenced by: Based on interview and record review the facility failed to ensure a resident was safely assisted from the facility van. The facility failed to ensure residents were supervised in common areas of the building resulting in physical altercations between residents. This failure resulted in R158 falling to the ground and sustaining multiple pelvic fractures. The facility failed to update a resident's comprehensive care plan following falls. This applies to 2 of 15 residents (R13 and R35) reviewed for safety and supervision in the sample of 15 and 1 resident (R158) outside the sample. The findings include: 1). 1. The facility's incident report dated August 4, 2017, showed on July 31, 2017, R13 struck R158 with a closed fist. The residents were separated. There were no injuries to either resident. The facility's intervention was to keep the residents away from each other. R158's nurses note dated July 31, 2017, showed at 6:30 PM, R158 was hit in the face and arm by a fellow resident (R13) and was calling the police. R158 stated "I was playing on my phone and he hit me in the face and on the arm." The local police arrived and spoke with the residents. R158's physician was called with a new order to	S9999			

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S9999	Continued From page 3 keep the residents apart. R158's nurses note dated November 19, 2017 at 6:20 PM, showed R158 was heard yelling in the community room at 3:45 PM. R158 was lying on the floor on her right side. R158 reported she was having pain in her tailbone and inner thighs. R158 was having difficulty trying to get up. R158 was transported to the local hospital by ambulance due to her pain and immobility. Another resident that had witnessed the incident reported that the perpetrator (R13) walked up to her and pushed her. At 9:30 PM, the local hospital was called for an update. R158 had multiple pelvic fractures. R158's hospital discharge summary dated November 27, 2017, showed R158 was admitted to the hospital following a fall in a nursing facility resulting in multiple closed pelvic fractures with disruption of the pelvic bone. The facility's incident report dated November 28, 2017 showed on November 19, 2017, facility staff responded to a report of R13 shoving R158 to the floor. The residents were separated and assessed. The nurse on duty stated she heard R158 yelling at R13 in an angry tone then heard a commotion. The nurse observed R158 lying on the floor in pain. An ambulance was called and R158 was transferred to the local hospital. The new intervention to be put in place was to keep the residents away from each other. R158's care plan was reviewed for interventions related to the resident to resident altercation of July 31st and November 19, 2017. There were no interventions listed. On June 7, 2018 at 2:11 PM, V2 (Director of Nurses) was asked if R13 and R158 were being	S9999			

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S9999	Continued From page 4 supervised and kept apart. V2 stated, "apparently not if he push her down." V2 stated there should have been interventions put in place after each incident. V2 was not aware of why the care plan was not updated. V2 stated it is important to keep the care plans updated so the staff know how to care for residents following falls and resident altercations. 2). 2. R35's Minimum Data Set (MDS) dated April 27, 2018 shows diagnoses to include obesity and muscle weakness. The MDS shows R35 is cognitively intact, and has no memory impairment. R35's December 20, 2017 at 12:00 nurse note shows "received report from DON (Director of Nursing) that patient fell backward in her wheelchair while out at an appointment and was sent to the ED (Emergency Department)." On June 7, 2018 at 8:37 AM, Z1 (Administrator) said the van driver notified him that R35 fell off the back of the lift, backwards, in her wheelchair. Z1 said R35 started moving while on the lift, tipped backwards and hit the ground. Z1 said R35 "started spasming in her wheelchair, is a bigger woman, and tipped the chair over backward." On June 7, 2018 at 10:08 AM, Z12 (Van Driver) said he was with R35 when she had her accident in the wheelchair. Z12 said he pushed R35 onto the facility van lift, locked her breaks, and turned around to operate the lift and saw her going over backwards. Z12 said the lift was up and R35 was suspended in the air 3-4 feet when she fell. Z12 said R35 "flipped over backwards". I was in the van and then tried to grab the wheelchair. We both went over and fell on the ground. Someone	S9999			

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NAME OF PROVIDER OR SUPPLIER

ROCHELLE GARDENS CARE CENTER

STREET ADDRESS, CITY, STATE, ZIP CODE

**1021 CARON ROAD
ROCHELLE, IL 61068**

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S9999	Continued From page 5 call 911 who saw the accident. Z12 said he felt like somehow R35 got over center on the fulcrum. Z12 said R35 doesn't ride in her wheelchair because it is too big, and needs to ride in a facility wheelchair that is smaller. She was "squeezed into a smaller chair". Z12 said there is 6-8 inch block that raises at the front and back of the ramp when it is in use. R35 went over the block at the back, and fell backwards in her chair, landing on her back. She fell about 3 feet from the ramp to the ground. On June 7, 2018 at 10:33AM, R35 said she fell over backwards in her wheelchair off the facility van lift and landed on the back of her head. R35 said she was taken to the hospital by an ambulance from the parking lot. R35 said "I thought I was gone when I fell, I hit my head so hard." R35 said she was going to get diabetic shoes, and she went in the facility van with Z12. R35 said they put her in a wheel chair that was too small for her because her wheelchair was too big for the van. R35 pointed to her wheelchair, and she was sitting in bariatric sized wheelchair. R35 said when they got to the store parking lot (Z12) came around, and unlocked the chair and moved her on the ramp out on the lift that extended off the back of the van. R35 said there is a "hump" the wheelchair has to go over to get out on the lift. R35 said (Z12) was in the van standing in front of her pushing her backwards and she was using her legs to help push over the bump because the chair wasn't moving. She said (Z12) was pushing her from the front, and she went straight over the back of the ramp. When he was pushing me out on the ramp I just kept going and flopped over backwards ...he was right there and went over and landed on top of me on the ground. R35 said she has not gone in the facility van since she tipped over backwards off	S9999		

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S9999	Continued From page 6 the ramp. At 11:33AM, Z12 turned the facility van on and activated the ramp and pointed to the raised back that stood about 8 inches in the air. The ramp was positioned 3-4 feet off the ground when it was extended off the back of the van. There was approximately a 2 inch incline from the facility van to the ramp. There was a raised area where the ramp met the facility van. Z12 said he was standing in front of R35 pushing her to the ramp when she fell. On June 8, 2018 at 11:20 AM, Z1 (Administrator) and Z2 (Director of Nursing) said there was no formal investigation done or report of an investigation into the R35's fall from the facility van. Z1 said he talked to R35 and the van driver but no incident report was done. Z2 said there were no new interventions put into place since the fall. Z1 said the facility wheelchair that R35 used the day she fell had a maximum weight capacity of 275-300 pounds. The December 2017 Monthly weight shows R35's weight as 319 pounds, and the January, 2018 form shows R35's weight as 319.7 pounds, almost 20 pounds higher than the maximum capacity weight for the wheelchair used to transport R35 on December 20, 2017. R35's care plan dated February 11, 2015 shows "resident is morbidly obese." R35's Fall risk care plan reviewed on April 30, 2018 does not have any interventions regarding the fall from the facility van.	S9999			

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