IDPH
ILLINOIS DEPARTMENT OF PUBLIC HEALTH
525-535 West Jefferson Street • Springfield, Illinois 62761-0001 • www.dph.illinois.gov

January 15, 2019

Daniel Maher, Registered Agent
Bravo Care of Elgin, Inc.
412 East Lawrence Street
Springfield, Illinois 62703

RE: Complaint #: IL00107225
Survey Date: November 15, 2018
Violation Type: Level A
Docket #: 19-C0001

Dear Registered Agent:

An investigation has been conducted by the Illinois Department of Public Health pursuant to a complaint concerning the long-term care facility known as Rosewood Care Ctr of Elgin.

Licensure

Pursuant to the provisions contained in the Nursing Home Care Act, or the ID/DD Community Care Act or the MC/DD Act, the Department must determine if each allegation in a complaint is valid, invalid or undetermined. The Department must also determine whether to cite a facility with one or more State violations or federal deficiencies (violations). The Department's determinations on the above referenced complaint are indicated on the attached "Complaint Determination Form." If your facility was cited with violations or deficiencies, then any rights you may have to a hearing will be described in the notices accompanying those violations or deficiencies.

If you have any questions, please contact the Division of Long-Term Care Quality Assurance at 217/782-5180 or, for the hearing impaired, the Department's TTY number at 1-800-547-0466.

Sincerely,

Sherry Barr

Sherry Barr
Division Chief of Quality Assurance
Office of Health Care Regulations

Enclosure
cc: Administrator
File
Rosewood Care Ctr of Elgin/November 15, 2018//RegAgent/S.Geer

DEPARTMENT OF PUBLIC HEALTH
STATE OF ILLINOIS

THE DEPARTMENT OF PUBLIC HEALTH STATE OF ILLINOIS, Complainant, v. BRAVO CARE OF ELGIN, INC., D/B/A, ROSEWOOD CARE CTR OF ELGIN, Respondent.	)))))))))	Docket No. NH 19-C0001

NOTICE OF TYPE "A" VIOLATION(S) AND ORDER TO ABATE OR ELIMINATE; NOTICE OF PLAN OF CORRECTION REQUIRED; NOTICE OF CONDITIONAL LICENSE; NOTICE OF FINE ASSESSMENT; NOTICE OF PLACEMENT ON QUARTERLY LIST OF VIOLATORS; NOTICE OF OPPORTUNITY FOR HEARING

Pursuant to the authority granted by the Nursing Home Care Act (210 ILCS 45/1-101 et seq.) (hereinafter, the "Act"), NOTICE IS HEREBY GIVEN:

NOTICE OF TYPE "A" VIOLATION(S) AND ORDER TO ABATE OR ELIMINATE

It is the determination of the Illinois Department of Public Health, State of Illinois, (hereinafter, the "Department") that there has been a failure by Respondent to comply with the Act. This determination is subsequent to a Complaint IL00107225 Investigation conducted by the Department on November 15, 2018, at Rosewood Care Ctr of Elgin, 2355 Royal Boulevard, Elgin, Illinois 60123. On January 14, 2018, the Department determined that such violations constitute one or more Type "A" violations of the Act and the Skilled and Intermediate Care Code, 77 Ill. Adm. Code 300 (hereinafter, the "Code"). The nature of each such violation and sections of the Code that were violated are further described in The Statement of Licensure Violations which is attached hereto and incorporated herein as Attachment A and made a part hereof.

Pursuant to Section 3-303 of the Act, the above-referenced facility is hereby ordered to abate and/or eliminate the above violation(s) immediately.

A Type "A" violation may affect your eligibility to receive or maintain a two-year license, as prescribed in Sec. 3-110 of the Act.

NOTICE OF PLAN OF CORRECTION REQUIRED

Pursuant to Section 3-303(b) of the Act and Section 300.278 of the Code, the facility shall have 10 days after receipt of notice of violation in which to prepare and submit a plan of correction. Any previous submissions are considered to be comments to the licensure findings and are not eligible as a plan of correction for this notice.

Each plan of correction shall be based on an assessment by the facility of the conditions or occurrences that are the basis of the violation and an evaluation of the practices, policies, and procedures that have caused or contributed to the conditions or occurrences. Evidence of such assessment and evaluation shall be maintained by the facility. Each plan of correction shall include:

1) A description of the specific corrective action the facility is taking, or plans to take, to abate, eliminate, or correct the violation cited in the notice.
2) A description of the steps that will be taken to avoid future occurrences of the same and similar violations.
3) A specific date by which the corrective action will be completed.

If a facility fails to submit a plan of correction within the prescribed time period, The Department will impose an approved plan of correction.

NOTICE OF CONDITIONAL LICENSE

In accordance with Sections 3-305 and 3-311 of the Act, the Department hereby issues a Conditional License for the operation of the Facility. This license replaces the unrestricted license issued to Rosewood Care Ctr of Elgin, 2355 Royal Boulevard, Elgin, Illinois 60123 on November 04, 2018. The Facility's current license number is 0049346. The term of the conditional license shall be from February 14, 2019 to August 13, 2019. THE CONDITIONAL LICENSE SHALL FOLLOW UNDER A SEPARATE COVER LETTER. THE CONDITIONAL LICENSE SHALL BE CONSPICUOUSLY POSTED IN THE FACILITY BEGINNING ON AUGUST 13, 2019.

The Conditional License will be withdrawn and an unrestricted license will be issued to Respondent upon the expiration of the term of the Conditional License.

During the term of the Conditional License, Respondent will retain its status as a certified provider of Medicaid services so long as Respondent's facility complies with the applicable federal regulations.

If the Respondent timely requests a hearing to protest the basis for the issuance of the Conditional License, the terms of the Conditional License shall be stayed pending the issuance of the Final Order at the conclusion of the hearing and the facility may operate in the same manner as with an unrestricted license.

NOTICE OF FINE ASSESSMENT

Pursuant to Section 3-305 of the Act the Department hereby assesses against Respondent a monetary penalty of **$25,000.00**, as follows:

Type A violation of an occurrence for violating one or more of the following sections of the Code: 300.610a), 300.1210b), 300.1210d)6), 300.1220b)3) and 300.3240a). The fine was doubled in this instance in accordance with 300.282i) and j) of the Code due to the violation of the sections of the Code with a high risk designation: 300.1210b), 300.1210d)6) and 300.3240a).

Section 3-310 of the Act provides that all penalties shall be paid to the Department within ten (10) days of receipt of notice of assessment by mailing a check (note Docket # on the check) made payable to the Illinois Department of Public Health to the following address:

Illinois Department of Public Health
P.O. Box 4263
Springfield, Illinois 62708

If the penalty is contested under Section 3-309, the penalty shall be paid within ten (10) days of receipt of the final decision, unless the decision is appealed and stayed by court order under Section 3-713 of the Act.

A penalty assessed under this Act shall be collected by the Department. If the person or facility against whom a penalty has been assessed does not comply with a written demand for payment within thirty (30) days, the Director shall issue an order to do any of the following:

DEPARTMENT OF PUBLIC HEALTH
STATE OF ILLINOIS

THE DEPARTMENT OF PUBLIC HEALTH STATE OF ILLINOIS Complainant, v. BRAVO CARE OF ELGIN, INC. D/B/A, ROSEWOOD CARE CTR OF ELGIN Respondent.	))))))))))	Docket No. NH 19-C0001

PROOF OF SERVICE

The Conditional License will follow under a separate cover letter.

The undersigned certifies that a true and correct copy of the attached Notice of Type "A" Violation(s) and Order to Abate or Eliminate; Notice of Conditional License; Notice of Fine Assessment; Notice of Placement on Quarterly List of Violators; and Notice of Opportunity for Hearing were sent by certified mail in a sealed envelope, postage prepaid to:

Registered Agent:	Daniel Maher
Licensee Info:	Bravo Care of Elgin, Inc.
Address:	412 East Lawrence Street Springfield, Illinois 62703

That said documents were deposited in the United States Post Office at Springfield, Illinois, on the 15th day of January, 2019.

Sammye Geer
Administrative Assistant
Long Term Care- Quality Assurance
Office of Health Care Regulations

(A) Direct the State Treasurer to deduct the amounts otherwise due from the State for the penalty and remit that amount to the Department;

(B) Add the amount of the penalty to the facility's licensing fee; if the licensee refuses to make the payment at the time of application for renewal of its license, the license shall not be renewed; or

(C) Bring an action in circuit court to recover the amount of the penalty.

NOTICE OF PLACEMENT ON QUARTERLY LIST OF VIOLATORS

In accordance with Section 3-304 of the Act, the Department shall place the Facility on the Quarterly List of Violators.

NOTICE OF OPPORTUNITY FOR A HEARING

Pursuant to Sections 3-301, 3-303(e), 3-309, 3-313, 3-315, and 3-703 of the Act, the licensee shall have a right to a hearing to contest this Notice of Type "A" Violation(s) and Order to Abate or Eliminate; Notice of Conditional License; Notice of Fine Assessment; and Notice of Placement on Quarterly List of Violators. In order to obtain a hearing, the licensee must send a written request for hearing no later than ten (10) days after receipt by the licensee of these Notices.

FAILURE TO REQUEST A HEARING WITHIN TEN DAYS OF RECEIPT OF THIS NOTICE WILL CONSTITUTE A WAIVER OF THE RIGHT TO SUCH HEARING.

FINE REDUCTION IF HEARING WAIVED

Pursuant to Sections 3-309 and 3-310 of the Act, a licensee may waive its right to a hearing in exchange for a 35% reduction in the fine. In order to obtain the 35% reduction in the fine, the licensee must send a written waiver of its right to a hearing along with payment totaling 65% of the original fine amount within 10 business days after receipt of the notice of violation.

Plans of Correction, Hearing and Waiver Requests can be emailed to the following email address: DPH.LTCQA.POCHearing@illinois.gov. If your facility does not have email capabilities then mail it to the attention of: Sammye Geer, Illinois Department of Public Health, Long Term Care – Quality Assurance, 525 West Jefferson, Springfield, IL 62761.

Sherry Barr

Sherry Barr
Division Chief of Quality Assurance
Office of Health Care Regulation

Dated this 15th day of January, 2019.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6014237	A. BUILDING: _____ B. WING _____	C 11/15/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROSEWOOD CARE CENTER OF ELGIN	2355 ROYAL BOULEVARD ELGIN, IL 60123

(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 #1877349/ IL#107225	S 000		
S9999	Final Observations Statement of Licensure Violation: 300.610a) 300.1210b)d)6) 300.1220b)3) 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 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	S9999	**Attachment A** **Statement of Licensure Violations**	

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S9999	Continued From page 1 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 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	S9999		

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S9999	Continued From page 2 resident. (Section 2-107 of the Act) These requirements were not met as evidenced by: Based on Observation, Interview and Record review the facility failed to ensure residents fall interventions were implemented. This resulted in (R1) sustaining a facial fracture and a burst fracture of the C6 vertebrae. This applies to 2 of 3 residents (R1 and R2) reviewed for falls in the sample of 11. The findings include; R1's Face sheet shows resident is a 95 year old male with the following diagnoses: Dementia, Hypertension, Diabetes Mellitus, Peripheral Vascular disease, Anemia, Hyperlipidemia, Osteoarthritis, Gastro-esophageal reflux, Chronic Kidney Disease, and Ectropion of left lower eyelid. R1's MDS (Minimum Data Set) assessment dated September 9, 2018 shows R1's cognitive status is moderately impaired. The MDS shows R1 requires extensive assistance for dressing, bed mobility, toilet use, and hygiene. R1 is totally dependent on (2) staff members for transferring resident with mechanical lift. R1's Care plan dated September 18, 2018 shows R1 has a history of falls and is at risk for falls related to decreased balance and inadequate safety awareness. R1's fall investigation report dated November 9, 2018, faxed to IDPH, shows R1 at 10:12 AM was in front of the nurse's station. Per witness ,V9's	S9999		

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S9999	Continued From page 3 (Insurance Case Manager) statement shows R1 was noticed sitting in his wheelchair by nurse's station and then she noticed resident was leaning forward, falling from chair and then hit his head on the ground. On November 13, 2018 at 3:02 PM, V3 LPN (Licensed Practical Nurse) stated she was not R1's nurse on November 5, 2018. V3 stated she was sitting at the nurse's station but was unable to visually see R1. V3 stated R1was a high fall risk. V3 stated all of the facility fall risk residents,on this unit, need to be visually monitored by all staff. V3 stated all fall risk residents on this wing are lined up at the nurse's station by the desk. V3 stated fall risk residents are kept in view and the facility always tries to have a staff member at the nurse's station desk. V3 stated an insurance case manager yelled; " He is going to fall" and we all ran towards R1. On November 13, 2018 at 11:00 AM, V1 (Administrator) stated R1 was at the nurse's station. R1 was trying to pick something off the floor and visitor tried to stop him. R1 was leaning over the wheelchair and he fell forward, hitting his head. V1 stated, according to the neurosurgeon at the hospital, he could not perform surgery so the family decided to remove R1 from life support and provide comfort care. R1 died the next day on November 6, 2018. V1 stated R1's personal safety alarms were removed and in place of them, the staff were to keep a visual eye on him. On November 13, 2018 at 12:00 PM, V2 DON (Director of Nursing) stated R1 had a low bed, his bed against the wall, mattress on the floor and a skid resistant pad for his wheelchair seat. V2 stated as far as she knows, R1's previous falls all happened in his room. V2 stated one of R1's	S9999		

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S9999	Continued From page 4	S9999		

interventions were to try to keep R1 in the dining room so staff could see him. V2 stated the facility no longer uses personal safety alarms at this time. V2 stated R1 was brought to the front of the nurse's station at approximately 10:00 AM. V2 stated she was notified R1 was on the floor and he was provided first aid, 911 was called and he was immobilized. V2 stated she was not sure if R1 was in staff's view.

On November 13, 2018 at 3:22 PM, V4 LPN (Licensed Practical Nurse) stated R1 was reaching for something but she could not understand what he was trying to say. V4 stated she did see R1's eye glass case on the floor after the fall. V4 stated the nurses and CNAs (Certified Nursing Assistants) are supposed to watch the fall risk patients but do not have enough time or staff to do it. V4 stated; "We cannot always be around the nurse's station, we have to pass meds." V4 stated; "We had a meeting and I ,with another nurse, spoke up that we needed more staff and the same response was given that 'we are working on it. " V4 stated on November 5, 2018, at the time R1 fell, she was sitting behind the nurse's station desk and did not see R1 fall until she ran around the nurse's station and he was already on the floor. V4 stated an insurance case manager was visiting and yelled that a resident was falling and "I jumped up and ran towards R1." V4 stated usually the fall risk residents are behind the nurse's station desk, V 4 said "I do not know why he was left in front of the nurse's station." V4 stated R1 usually lays down. V4 stated once after R1 fell we had him at the nurse's station because he was trying to get up from his wheelchair.

On November 14, 2018 at 9:50 AM, V5 (Coroner)

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S9999	Continued From page 5	S9999		

stated he spoke with the ER staff at the hospital regarding R1. V5 stated V11 (ICU Physician) documented R1's cause of death is related to the fall and hypoxia. The tentative death of R1 is fall related and in addition, hypercapnia. V5 stated the coroner's case is still open until all medical records are received.

On November 14, 2018 at 10:10 AM, V6 (R1's wife) stated R1 broke his neck and nose. V6 stated he died related to the fall and it was a terrible situation. V6 stated R1 fell multiple times times. V6 stated ;"it was very concerning to me." V6 stated R1 should have not fallen like he did. V6 stated she felt the facility should have put something in or on his chair or do something that would prevent him from falling. V6 stated she was married to R1 for over 32 1/2 years and he will be truly missed.

On November 14, 2018 at 11:00 AM, V7 RN (Registered Nurse) stated on November 5, 2018 at 9:40 AM she was getting her folder from the 400 hall wing office for a meeting. V7 stated and she saw R1 at a table in the dining room asleep with a tray on his lap and a bowl of cereal, spoon and fork on his leg. V7 stated she tapped R1's shoulder and asked if a CNA (Certified Nursing Assistant) could change him . When V7 and R1 reached the nurses station, all CNAs and nurses were at the nurses station for morning meeting. V7 stated she told R1's CNA that he spilled cereal on his lap and needed to be changed. V7 stated she put R1 by the outer part of the nurse's station where the aide could see R1. V7 stated she was not sure if R1's CNA changed his clothes. V7 stated R1 fell at the spot she put him. V7 stated ,most of the time, if a resident is a fall risk they have to be in staff's view at the nurse's station where staff are present. V7 stated the reason

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S9999	Continued From page 6	S9999		

she did not place R1 behind the nurses station is because all the staff where behind the desk. V7 stated if R1 is confused, a staff member will sit with him and chart. V7 stated "we remind staff in the am meetings who are frequent fallers and who need to go to bed to prevent falls." V7 stated there is no specific time frame implemented on checking fall risk patients. V7 stated the facility did away with alarms and thought alarms were more convenient for the staff. Alarms would not stop resident from falling. V7 stated the staff should check on the residents physically. V7 stated the facility looks at the falls based on how the resident falls and then implement interventions.

R1's Hospital records were reviewed and showed V11 (Neurosurgeon) explained to V6 (R1's wife) that R1 was not a reasonable candidate for his neck fracture. In addition, R1's cause of death was respiratory failure due to airway compromise, due to a burst fracture of the C6 vertebrae which was the result of an accidental fall. A burst fracture is a descriptive term for an injury to the spine in which the vertebral body is severely compressed. Burst fractures typically occur from severe trauma such as a fall.

2. R2's face sheet showed resident with the following diagnoses: Parkinson's disease, Benign hypertrophy, Anemia, Anxiety, Urinary Tract Infection, Hypertension, Diabetes Mellitus, Dementia, Psychosis and Major Depression.

On November 13, 2018 at 9:45 AM, R2 was at the nurse's station behind the desk sleeping in his wheelchair. V3 LPN (Licensed Practical Nurse) stated R2 was sitting behind the nursing station desk because he was a fall risk. R2 was noticed with his wheelchair brakes on and his body was

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S9999	Continued From page 7	S9999		

pushed up against the desk. V3 stated she had to go to the bathroom. No staff were at the nurse's station or in the dining room to view R2 for 18 minutes consecutively. R2 woke up and started to push back on his wheelchair that was locked. V3 returned from the bathroom and was told R2 was pushing himself back in his wheelchair trying to move away from the desk. V3 stated staff should have been at the desk to monitor him.

R2's Fall Risk Care Plan dated November 2, 2018 to present shows resident is alert to person and place with episodes of confusion; exhibits poor safety awareness and unsafe attempts to transfer self without assistance and last known fall was on September 1, 2018. R2's interventions are as follows: to be monitored frequently and keep within sight of staff and to monitor frequently and anticipate his needs.

On November 13, 2018 at 10:30 AM, V2 DON (Director of Nursing) was told R2 was left at the nurse's station behind the desk with no one at the nurse's station or in the dining room from 10:02AM to 10:20 AM. In addition, V2 was told R2 was trying to stand but his wheelchair brakes were locked. V2 stated R2 is positioned at the nurse's station so that staff would be able to see him to prevent him from standing and falling.

On November 13, 2018 at 2:00 PM, V1 (Administrator) stated R2 is positioned in the nurses station, behind the desk, because he was a high fall risk. V1 stated R2 should not have been left alone at the nurse's station and not in sight of a staff member. V1 stated R2 should monitored and should be kept within sight of staff members.

On November 13, 2018 at 11:00 AM, V1 stated

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S9999	Continued From page 8 R2 has a history of falls and tries to get up and down all the time . Staff walk with R2, do activities, 1:1, and R2 is placed behind the nurse's station to keep him with someone. V1 stated R2 has not fallen recently since these interventions mentioned above. The Facility's Incidents/Accidents Policy and Procedure Revised October 2018 shows: The facility will take every precaution to prevent the occurrence of accidents...An incident may defined as, but is not limited to falls, resident injuries of known or unknown origin, or any occurrence of an unusual nature that requires investigation. (A)	S9999		

LTC07202 COMPLAINT DETERMINATION FORM

FAC. NAME: ROSEWOOD CARE CTR OF ELGIN COMPLAINT #: 0107225
LIC. ID #: 0049346
DATE COMPLAINT RECEIVED: 11/09/18 11:54:00

IDPH Code	Allegation Summary	Determination
105	IMPROPER NURSING CARE	1
131	RESIDENT INJURY	1

X The facility has committed violations as indicated in the attached*
___ No Violation

*Facilities participating in the Medicare and/or Medicaid programs will not receive a copy of the certification deficiencies as they have already received a copy through the certification program process.

Determination Codes

1 = VALID - A complaint allegation is considered "valid" if the Department determines that there is some credible evidence that there has been a deficiency (non-compliance with the Act or rules & regulations) relating to the complaint allegation.

2 = INVALID - A complaint allegation is considered "invalid" if the Department determines that there is no credible evidence that there has been a deficiency (non-compliance with the Act or rules & regulations) relating to the complaint allegation.

3 = UNDETERMINED - A complaint allegation is considered "undetermined" if the Department finds there is insufficient information reported to initiate or complete an investigation.

RESIDENT INJURY - Per the P&A v. Lumpkin consent decree, allegations of resident injury will always be "valid" if the resident who is the subject of the allegation was injured.