Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6003065	A. BUILDING: ______ B. WING ______	C 02/17/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROSICLARE REHAB & HCC	55 FERRELL ROAD ROSICLARE, IL 62982

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S 000	Initial Comments Investigation of Facility Reported Incident of Januray 19, 2023/IL156590	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.1210b)5) 300.1210c) 300.1210d)6) 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 resident to meet the total nursing and personal care needs of the resident.	S9999	Attachment A Statement of Licensure Violations	

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S9999	Continued From page 1 5) All nursing personnel shall assist and encourage residents with ambulation and safe transfer activities as often as necessary in an effort to help them retain or maintain their highest practicable level of functioning. 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. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to ensure a gait belt was used when transferring/lifting a resident for 1 (R2) of 3 residents reviewed for accidents in a sample of 7. This failure resulted in R2 sustaining a right proximal humerus fracture and inferior subluxation of the humeral head as it relates to the glenoid. This past non-compliance occurred between 1/19/23 and 1/25/23. The findings include: R2's New Admission Information documents that R2 was admitted to the facility on 8/10/18. R2's Physician's orders dated 2/1/23-2/28/23	S9999		

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S9999	Continued From page 2	S9999		

document diagnoses including Acute Ischemic Left MCA (Middle Cerebral Artery) Stroke, CKD (Chronic Kidney Disease), IDDU (sic Insulin Dependent Diabetes Mellitus), dysphagia, dialysis, seizures, Proximal Right humerus fracture.

R2's MDS (Minimum Data Set) dated 1/26/23, Section C documents a BIMS score of 06, which indicates that R2 has severe cognitive impairment. Section G of the same MDS documents for transfers, R2's self-performance is total dependence, and the support provided is two plus physical assist.

R2's (undated) care plan documents a problem area of Self-care deficit - needs assist to complete quality care ADL's (Activities of Daily Living) with a corresponding intervention of (mechanical) lift for transfer with a start date of 12/5/18.

A report titled "Final Investigation" dated 1/27/23 documents the following: "On 01/19/2023 at approximately 2:30 PM, CNA's (V3) and (V4) were repositioning (R2) in preparation for her shower in a geri chair to get (R2) realigned with the (name of mechanical lift) sling that was underneath her. (R2) was sitting at an angle on the (name of mechanical lift) sling to where they couldn't get it properly around her and attached to (name of mechanical lift) lift. When they went to reposition (R2), (V3) heard a loud pop noise. At which point (V4) stayed with (R2) while (V3) went and notified nurses immediately. Ambulance was notified, and (R2) was sent over to ER (emergency room) for X-rays and returned to facility at approximately 7:30 PM with immobilizer to right arm at all times except for care." The report continues to document "X-ray results were

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S9999	Continued From page 3 obtained and revealed inferior subluxation of the humeral head as it relates to the glenoid and a proximal right humerus fracture...In conclusion, the facility was able to conclude that (R2's) injury resulted while being repositioned. QA (Quality Assurance) committee met, and new interventions were discussed, and her care plan has been updated to reflect her current status." On 2/16/23 at 9:15am, V1 (Administrator) said that they had a QA meeting on 1/20/23 after the incident when R2 was injured and placed a new intervention of gait belt training with staff. V1 said she conducted the in-service with all staff on 1/25/23. V1 said that R2 was sitting in her chair and the mechanical lift sling was underneath R2. V1 said the sling had slid down in an awkward position and that V3 (CNA/Certified Nurse Assistant) and V4 (CNA) lifted/repositioned R2 to get the sling under her right. V1 said V3 and V4 heard a pop sound after lifting/repositioning R2 and immediately got the nurse. V1 said that the two CNAs did not use a gait belt when repositioning/lifting R2. V1 said that staff are made aware of the gait belt policy upon hire and that gait belts are mandatory. On 2/16/23 at 1:15pm, V4 (CNA) said that she did not use a gait belt when repositioning R2. V4 said that V3 and herself each took a side a put their arms underneath R2's (arms) and lifted her enough to get sling straightened up. V4 said they then heard a pop and immediately went to get the nurse. V4 said that she was aware of the gait belt policy and did get in-serviced on use of belt after incident. V4 said she does not know why she did not use the gait belt but knows she should have. On 2/16/23 at 2:00pm, V3 (CNA) said she is still upset over R2 being injured and does not know	S9999		

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S9999	Continued From page 4 why she didn't use a gait belt. V3 said R2's lift sling had slid underneath her and they needed to get it straightened up to lift her using the mechanical lift. V3 said that she and V4 lifted R2 by putting their arms under R2's arms and had another staff straighten the pad. V3 said while lifting R2, they heard a pop and immediately sat her down. V3 said that R2 complained of pain right after the pop. V3 said they went and got the nurse immediately. V3 said she did receive in-service after the incident and was aware of the gait belt policy. A document titled "Results" from the local hospital notes that on 1/19/23, R2 had an x-ray shoulder right 2 plus views. The impression documents "1. Proximal right humerus fracture, 2. Inferior subluxation of the humeral head as it relates to the glenoid." R2's Physician's Orders dated 2/1/23 to 2/28/23 document an order (carried over from January 2023) dated 1/19/23 for immobilizer to Rt (right) arm @ (at) all times except during care. A facility document labeled "Policies" documents V3 received training on the Gait Belt Policy and signed the proof of completion on 7/15/22. V4 is documented as receiving the training and signing the proof of completion on 5/17/21. A facility document labeled facility Transfer Belts/Gait Belts revised 12/17/12 notes in part that all certified nursing assistants and licensed nursing personnel engaged in the lifting and transferring of residents will use gait belts...Gait belts are mandatory. Prior to the survey date, the facility implemented the following actions to correct the deficient	S9999		

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S9999	Continued From page 5 practice: 1. A Quality Improvement Meeting was held on 1/20/23, documenting discussion of R2's fall resulting in unspecified fracture of the humerus. New interventions listed on the form note "gait belt training with staff." The following staff were noted to be in attendance to this meeting: V1 (Administrator), V2 (Director of Nursing/DON/MDS Coordinator), V8 (Business Office Manager), V9 (Maintenance), V10 (Housekeeping/Laundry/Medical Records), V11 (Social Service/Activities Director), and V12 (Food Service Supervisor). 2. A facility "Inservice/Class Attendance" form dated 1/25/23 with the title of the in-service noted as "Proper Gait Belt Usage and Positioning" documents V1 (Administrator) provided instruction on the following areas of instruction: "Gait belt should be used for all transfers, repositioning in chair, and assistance with mobility. Prior to moving resident make sure leg pegs are out of the way to avoid skin tears or injuries. Belt position is low and tight. One person on each side of resident; if resident is sliding down have a third person in front of resident for safety and assistance." Additional documentation provided by V1 documents that V13 (Therapy Department) assisted in providing Gait Belt Training. "B"	S9999		