STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145971	A. BUILDING _____ B. WING _____	C 02/07/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROSEWOOD CARE CENTER NORTHBROOK	4101 LAKE COOK ROAD NORTHBROOK, IL 60062

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F 323	Continued From page 3 wheel herself to different areas of the facility. Facility's incident investigation of R3's 11/23/11 fall incident showed that no staff was with R3, when R3 went to the basement by herself. E3 and E4, both assigned to R3 on 11/23/11 also verified that they were not with R3, when R3 fell at the basement. E3 last saw R3 on 11/23/11 at 5 PM by herself at the Assisted Dining Room, and even questioned other staff if they wheeled R3 to the Assisted Dining Room, as E3 saw R3 by the nurses station prior to this. On 1/20/12, E6 and E4 both said at 12:15 PM and 2:45 PM, that they have seen R3 by the big dining room before. The big dining room area is in front of the elevator that goes down to the basement. Per R3's 11/23/11 report, R3 was found unsupervised on the basement floor. Her alarm was also not triggered, and it is the same device she has been using after her 11/4/11 fall. R3 sustained laceration at the left forehead and hematoma, which resulted to her hospitalization on 11/23/11. R3's hospital record printed on 11/26/11 indicated that she had contusion, abrasions, and subgaleal hematoma. Her 12/9/11 office visit also shows that R3's 3.5 x 7 cm hematoma over the left eye was persistent, that an Incision and Drainage of the Hematoma was performed at the office.	F 323		
F9999	FINAL OBSERVATIONS Licensure Violations: 300.610a)	F9999		

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F9999	Continued From page 4 300.1210a) 300.1210b)5) 300.1210d)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 which 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. These policies shall be in compliance with the Act and all rules promulgated thereunder. These written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, as evidenced by written, signed and dated minutes of such a meeting. Section 300.1210 General Requirements for Nursing and Personal Care a) Comprehensive Resident Care Plan. A facility, with the participation of the resident and the resident's guardian or representative, as applicable, must develop and implement a comprehensive care plan for each resident that includes measurable objectives and timetables to meet the resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment, which allow the resident to attain or maintain the highest practicable level of independent functioning, and provide for discharge planning to the least restrictive setting based on the resident's care needs. The assessment shall be developed with	F9999		

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F9999	Continued From page 5 the active participation of the resident and the resident's guardian or representative, as applicable. (Section 3-202.2a of the Act) 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: 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. 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 are not met as evidence by: Based on interview and record review, the facility	F9999		

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F9999	Continued From page 6	F9999		

failed to provide supervision and put in place interventions to prevent 1 resident who has a fall history, from going to the basement unsupervised, and falling to the floor without her chair alarm on, out of 4 residents (R3) reviewed for falls. R3 was hospitalized and sustained Contusion and Subgaleal Hematoma to the left eye.

Findings include :

R3 has diagnoses of Left Hip Replacement, Dementia, Arthritis, Restless Leg Syndrome, Hypertension, and Atrial Fibrillation.

R3's Incident Report indicated that on 11/4/11 at 3:15 PM, R3 was found in the bathroom lying on the floor, with her buttocks on the wheelchair leg rest, and her left hand holding on to the bathroom rails. R3 was found in the bathroom alone without staff supervision, after her wheelchair alarm triggered.

On 1/20/12 at 2:55 PM, E5 (nurse) said that on 11/4/11, she found R3 sitting on her wheelchair foot rest in her bathroom, after her chair alarm sounded. E5 said R3 was by herself. E5 continued that her wheelchair alarm was reapplied, and R3 was placed in the Assisted Dining Area.

R3's 11/23/11 incident report indicated that at around 5:10 PM, R3 was again found in the facility basement, lying on the floor.

On 1/20/12 at 2:45 PM, E4 (nurse aide assigned to R3) said that she last saw R3 by the nurses station, when she took her break around

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4:30 PM. After her break, E4 said that E6 (housekeeper/laundry) called E7 (nurse) to go downstairs. E4 said she went with E7 to the basement, and saw R3 on the floor, away from her wheelchair. E4 said that R3 was bleeding. E4 also said that she did not remember hearing R3's alarm, but knows that her alarm was attached to her wheelchair. E4 added that R3 would wheel herself to the hallways, and even to the big dining room, which is located in front of the elevator that leads to the basement. E4 said that R3 had tried to stand up before from her wheelchair, but cannot really stand up good. E4 also said that R3 had fallen before, and had only been using a chair alarm prior to her 11/23/11 fall.

According to E3 (nurse) on 1/20/12 at 2:25 PM, the last time she saw R3 on 11/23/11 prior to being found in the basement, R3 was in the Assisted Dining Room in front of the TV. E3 said that prior to that, R3 was placed by the nurses station. E3 said that she was later alerted by staff, that R3 was found in the basement floor. E3 said she does not remember hearing R3's chair alarm during the incident. E3 also said that she thinks that R3 had fallen in the bathroom before the 11/23/11 incident.

E6 (housekeeper/laundry) said on 1/20/12 at 12:15 PM, that she was working in the laundry room which is near the basement elevator, when she heard R3 scream for help. E6 said that when she went out of the laundry room door, she saw R3 in front of her wheelchair with her face down on the floor. E6 continued that the wheelchair was across the elevator. E6 also said that she did not hear R3's chair alarm, when she found R3.

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R3's 9/29/11 Risk for Falls care plan showed, that her 11/4/11 fall was added in the care plan. However, review of facility's fall investigation did not really determine what caused R3 to fall on 11/4/11. R3 fell from her wheelchair because she was on the toilet without any staff supervision, and cannot be left by herself in areas she shouldn't be at, unsupervised. Added to this, R3's chair alarm did not really alert the staff to assist her in time, to prevent her from falling. R3's wheelchair alarm mainly alerted E5 that R3 had already fallen in the bathroom. Despite this, there was no new intervention put in place immediately after the 11/4/11 fall, to prevent R3 from falling further. Per R3's care plan, a urinalysis and urine culture and sensitivity was only initiated on 11/7/11. It also did not discontinue or replace or revise R3's use of chair alarm, although it does not prevent R3 from falling. R3 should also not be left by herself in areas not monitored by staff, as staff is aware R3 can unlock her wheelchair, and wheel herself to different areas of the facility.

Facility's incident investigation of R3's 11/23/11 fall incident showed that no staff was with R3, when R3 went to the basement by herself. E3 and E4, both assigned to R3 on 11/23/11 also verified that they were not with R3, when R3 fell at the basement. E3 last saw R3 on 11/23/11 at 5 PM by herself at the Assisted Dining Room, and even questioned other staff if they wheeled R3 to the Assisted Dining Room, as E3 saw R3 by the nurses station prior to this.

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F9999	Continued From page 9 basement. Per R3's 11/23/11 report, R3 was found unsupervised on the basement floor. Her alarm was also not triggered, and it is the same device she has been using after her 11/4/11 fall. R3 sustained laceration at the left forehead and hematoma, which resulted to her hospitalization on 11/23/11. R3's hospital record printed on 11/26/11 indicated that she had contusion, abrasions, and subgaleal hematoma. Her 12/9/11 office visit also shows that R3's 3.5 x 7 cm hematoma over the left eye was persistent, that an Incision and Drainage of the Hematoma was performed at the office. (B)	F9999		