

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145646 | (X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____ | | (X3) DATE SURVEY COMPLETED C 03/19/2013 |
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| NAME OF PROVIDER OR SUPPLIER ROSEWOOD CARE CENTER OF EAST PEORIA | | | STREET ADDRESS, CITY, STATE, ZIP CODE 900 CENTENNIAL DRIVE EAST PEORIA, IL 61611 | | |
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| F 323 | Continued From page 3 (CNA) came to E6 and asked E6 to look at the mechanical lift and stated it fell over while a resident (R1) was in it. E6 stated questioning E5 asking if the legs of the mechanical lift were open during transfer and E5 stated "no." | F 323 | | | |
| F9999 | The facility's weight record for R1 documents on 1/23/13 R1 weighed 351.9 pounds. The mechanical lift User Instruction Manual documents 500 pounds patient lift. FINAL OBSERVATIONS LICENSURE VIOLATIONS 300.1210d)6) 300.3240a) Section 300.1210 General Requirements for Nursing and Personal Care 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. | F9999 | | | |

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| F9999 | Continued From page 4 THESE REQUIREMENTS ARE NOT MET AS EVIDENCED BY: Based on observation interview and record review the facility failed to ensure the safety during repositioning and failed to use mechanical lifts correctly for one of four residents (R4) reviewed for safety during transfers in a sample of four. R4 fell out of bed during repositioning and sustained a laceration requiring sutures. Findings include: 1. R4's most recent MDS (Minimum Data Set) signed 9/21/12 documents R4 needs extensive assistance and two plus persons physical assist for bed mobility and transfers. R4's Weekly Summary dated 2/19/13 and 3/5/13 documents for transfers, requires assist of 2. The weekly summary documents R4 needs turned and repositioned by staff every 2 hours. R4's Physical Therapy discharge summary dated 10/15/12 documents for bed mobility R4 is maximum to moderate assist with verbal and tactile cues. R4's Assistive Device/Restraint assessment dated 10/5/12, 10/24/12 and 3/5/13 documents R4 is always confused, history of falls, safety awareness deficit, unable to get out of bed unassisted and poor balance. The assessment dated 10/5/12 also documents R4 is unable to follow commands. R4's Quarterly Fall Risk Assessment documents R4 has impaired vision, unsteady gait, confused/disoriented, poor balance, weakness and poor judgement or decision making. | F9999 | | | |

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| F9999 | <p>Continued From page 5</p> <p>The Facility's Incident and Accident log documents R4 had falls on 2/11/13 and 3/7/13.</p> <p>The Facility's Incident/Accident witness statement documents E5 CNA (Certified Nursing Assistant) was rolling R4 in bed and " (R4) rolled right out of bed." The Facility's Report of Serious Incident or Accident form Incident Summary documents "while CNA (E5) was rolling (R4) to provide cares (R4) rolled out of bed onto the floor." Resident was sent to hospital where (R4) received stitches for a laceration on the forehead. The Facility's Incident Investigation form dated 2/11/13 documents R4 had a fall with a laceration on the forehead. The Commentary section of the investigation form documents R4 "received a bloody nose and a laceration to forehead, sent to hospital, received stitches."</p> <p>R4's Narrative Nurse's Progress Notes document on 2/12/13 "R (right) eye swollen, purple bruising, stitches forehead intact."</p> <p>R4's Hospital Emergency Department record documents the date of visit for R4 was 2/11/13 with fall as the chief complaint. The procedures documented for R4 are Routine Laceration Repair with a diagnosis of "cut on Face." The Discharge instructions for R4 included "sutures out in 5 days."</p> <p>Post investigation action for R4's fall on 2/11/13 included staff inservices. The Facility's In-Service Education/Meeting attendance sheets were provided for 2/11/13 and 2/12/13 by E1 (Administrator). The attendance sheet for 2/11/13 documents for the subject of the meeting, resident turning and repositioning and 2/12/13</p> | F9999 | | | |

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| F9999 | <p>Continued From page 6</p> <p>subject was turning and repositioning every 2 hours. E5 CNA (Certified Nursing Assistant involved in fall on 2/11/13) did not attend either inservice on 2/11/13 or 2/12/13. The new intervention documented was to always use 2 people when rolling R4.</p> <p>On 3/13/13 at 9:30 a.m. E5 (CNA) stated on 2/11/13 E5 was changing R4 and put R4 on her side. E5 stated that while holding R4 with one hand E5 reached for a wet wipe and felt R4 moving, tried to grab R4 but R4 still fell.</p> <p>On 3/14/13 at 2:45 p.m. E2 DON (Director of Nursing) verified that E5 (CNA) did not attend the inservices on 2/11/13 and 2/12/13.</p> <p>The Facility's Report of Serious Incident or Accident form documents on 3/7/13 2 CNA's (Certified Nursing Assistants E5 and E7) were transferring R4 via mechanical lift from the wheelchair to the bed and during the transfer R4 fell onto the right hip and head. (R4) sustained a hematoma and was transferred to a hospital for evaluation. The facility's Incident/Accident report documents "swelling" as the type of injury that occurred. The Facility's Incident/Accident witness statement dated 3/7/13 and signed by E5 (Certified Nursing Assistant) documents under the section of the form titled describe what you saw/heard: was using mechanical lift to put in bed and R4 "slid right out of it, I told E7 CNA (Certified Nursing Assistant) to put her back in the chair, not safe. she (E7) said let's put (R4) in bed real quick then (R4) slid out. I'm not happy and feel really bad." The Facility's Incident/Accident witness statement dated 3/7/13 and signed by E7 CNA (Certified Nursing Assistant) documents</p> | F9999 | | | |

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| F9999 | <p>Continued From page 7</p> <p>under the section titled describe what you saw/heard: "assisted the resident (R4) with a mechanical lift and fasten up the resident (R4) in the mechanical lift pad and resident (R4) after proceeding to move the mechanical lift to her (R4) bed. Resident (R4) fall out of bed." R4's weight assessments were included with the investigation and documented R4's weight was 195.1 pounds. E1's (Administrator) summary of the Incident on 3/7/13 documents "Resident's (R4) head was on the foot of the mechanical lift and was laying on right side. The sling was still hanging on the mechanical lift. I (E1) checked the mechanical lift sling which was noted to be the wrong size." The sling was an XL. The CNA's (E5 and E7) were instructed to re enact the transfer. Initially they placed the sling upside down. "From Questioning the CNA's (E5 and E7) it appears that they (E5 and E7) used the wrong size sling and they did not attach the Velcro properly." The summary also documented E5 (CNA) stated "she knew it was the wrong size sling." The Facility's Incident Investigation documents for R4 the type of incident was a fall with description of injury as a bump to the back of the head. The commentary for R4's fall from the mechanical lift on the same form documents "while being transferred by 2 staff (E5 and E7) members with the use of mechanical lift resident (R4) inadvertently slipped out of sling landing body on floor. Resident (R4) alert and C/O (complain of) headache. Small bump noted to back of head." Post investigation actions on the same form were staff inservices.</p> <p>Facility inservice dated 1/12/13, 1/15/13, 1/18/13 and 1/29/13 titled mechanical lift usage contains no documentaion that E5 (CNA) attended.</p> | F9999 | | | |

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| F9999 | <p>Continued From page 8</p> <p>The Facility's Total Resident Transfers Using Mechanical Lifts Policy dated 3/31/08 documents: "Operation, use, weight limits and maintenance requirements are different for each brand and model of mechanical lift. Trained employees must follow the manufacturers directions when using the lifts." The Facility's Sling Formulary documents; "Access slings designed specifically for toileting. User weight for XL sling is 275 to 500 pounds and L is for 175-300 pounds. R4's weight was 195 and according to the Facility's Sling Formulary the L sling was the appropriate sling to use.</p> <p>On 3/13/13 at 10:00 a.m. E7 CNA (Certified Nursing Assistant) stated taking R4 to room on 3/7/13. The mechanical lift pad was new, E7 stated E5 Velcro the mechanical lift pad around R4 and the Velcro looked and felt ok. The sling was then attached to the mechanical lift and we started raising (R4) and when I (E7) turned the mechanical lift (R4) fell out. E7 stated she felt the sling was the right size but that the Velcro on the sling was not secured. E7 stated she was not rushing and was never instructed that the sling was the wrong size.</p> <p>On 3/13/13 at 9:30 a.m. E5 CNA (Certified Nursing Assistant) stated on 3/7/13" E7 (Certified Nursing Assistant) wanted to use mechanical lift on R4 and I (E5) was upset from the previous incident (rolling R4 out of bed on 2/11/13). We were using a half sling (Access sling) and I (E5) don't think they are safe. I instructed E7 3 times that the sling was too big and E7 said lets just move her (R4) real quick. I (E5) have reported to the Administrator (E1) that the 1/2 slings were an accident waiting to happen and she (E1) said</p> | F9999 | | | |

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| F9999 | <p>Continued From page 9</p> <p>that's what we are using." E5 stated on 3/7/13 E5 and E7 were moving R4 from the chair to bed with the mechanical lift and when R4 was lifted up in the mechanical lift it was raised and turned so that the legs of the mechanical lift were aligned with the bed and that is when R4 fell between bed and chair."</p> <p>On 3/14/13 at 1:45 p.m. Z2 (representative for mechanical lift and sling) stated the Access Sling (1/2 sling) is used specifically for the toileting process and is not a general purpose sling. The sling only suits 25% of residents and is not designed for general use. On 3/14/13 at 2:00 p.m. Z3 (representative for mechanical lift and sling, technical support) stated the Access sling (1/2 sling) is a true hygenic sling and is not good for general use. The resident the sling is to be used on needs good upper body strength to be able to hold on.</p> <p>On 3/14/13 at 2:45 p.m. E2 DON (Director of Nursing) confirmed upper body strength on R4 was poor.</p> <p>On 3/13/13 at 11:10 a.m. E8 and E9 CNA's transferred R4 from the bed to the wheelchair. While the CNA's were raising the mechanical lift R4 kept stating "I don't like this." R4 was then placed in the wheel chair with the use of a half lap tray, pommel cushion and foot board. On 3/14/13 at 1:20 p.m. E9 and E16 CNA's (Certified Nursing Assistants) were transferring R4 via mechanical lift from the wheelchair to the bed. E9 was raising R4 from the chair with the mechanical lift and R4 kept saying "set me down." After the CNA's placed R4 in bed they began to roll R4 back and forth to remove the sling out from under her. R4</p> | F9999 | | | |

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| F9999 | <p>Continued From page 10</p> <p>grabbed E16's shirt and said "please don't roll me."</p> <p>On 3/14/13 at 1:30 p.m. E9 CNA (Certified Nursing Assistant) stated R4 is nervous when staff is rolling her in bed and when using the mechanical lift she is more comfortable with certain people. E9 stated when R4 is rolled she becomes anxious, frustrated, grabs and can become combative. E9 stated R4 can be rolled with just one staff member but E9 likes to use 2 people.</p> <p>On 3/14/13 at 1:30 p.m. E16 CNA (Certified Nursing Assistant) stated he tries not to use the access sling because they do not feel safe and there is no support for the residents bottom. E16 stated he tries to avoid using the access sling. E16 stated R4 is nervous when being rolled. E16 states R4 can be rolled with assist of 1 but some staff need to use 2 people. E16 stated when rolling R4 to roll R4 towards you. E16 states R4 gets scared when she is rolled then stated "can you blame her.</p> <p style="text-align: center;">(B)</p> | F9999 | | | |