**NAME OF PROVIDER OR SUPPLIER:** ASTA CARE CENTER OF ROCKFORD  
**STREET ADDRESS, CITY, STATE, ZIP CODE:** 707 WEST RIVERSIDE BOULEVARD, ROCKFORD, IL 61103

<table>
<thead>
<tr>
<th>ID PREFIX</th>
<th>TAG</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)</th>
<th>ID PREFIX</th>
<th>TAG</th>
<th>PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)</th>
<th>COMPLETE DATE</th>
</tr>
</thead>
</table>
| S 661     |     | Continued From page 1  
on record. E4's fingerprints were obtained on 9/8/12 which showed a "hit" for 5 disqualifying offenses. When brought to the attention of E1 (Administrator) another HCWBC was run on 10/15/13 which again showed E4 had 5 disqualifying offenses for drug trafficking/delivery and was not eligible for employment unless a waiver had been granted. There was no waiver on file. E1 stated E4 "slipped through" somehow. E1 stated he suspended E4 at 1:20 PM 10/15/13. | S 661     |     |                                                                                |               |
| S9999     |     | Final Observations  
Licensure Violations:  

- 300.810a)  
- 300.810b(1)(2)(3)(4)  
- 300.820f)  
- 300.840  
- 300.1210b)  

Section 300.810 General  
a) Sufficient staff in numbers and qualifications shall be on duty all hours of each day to provide services that meet the total needs of the residents. As a minimum, there shall be at least one staff member awake, dressed, and on duty at all times. (A, B)  
b) The number and categories of personnel to be provided shall be based on the following:  
1) Number of residents.  
2) Amount and kind of personal care, nursing care, supervision, and program needed to meet | S9999     |     |                                                                                |               |
Continued From page 2

the particular needs of the residents at all times.

3) Size, physical condition, and the layout of the building including proximity of service areas to the resident's rooms.

4) Medical orders.

Section 300.820 Categories of Personnel

f) The facility shall provide nursing personnel as set forth in Subpart F.

Section 300.840 Personnel Policies

The personnel policies required in Section 300.650, Section 300.651, and other personnel policies established by the facility, shall be followed in the operation of the facility.

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.

These Requirements are not met as evidenced by:
Based on observation, interview and record review, the facility failed to provide staffing to meet the transfer, toileting and personal cares including shaving, nail cleaning, and showers, to residents in a timely manner. This failure resulted in R8 obtaining a laceration to his left leg. The wound resulted in profuse bleeding and 10 sutures being placed at the local Emergency Department.

This applies to 7 of 13 residents (R4, R5, R8, R9, R11, R12 & R13) reviewed for care provision.

The findings include:

R8 was admitted to the facility on 5/8/13 with diagnoses to include Depression, Atrial Fibrillation, Sacral Decubitus, Chronic Obstructive Pulmonary Disease and Vitamin D deficiency according to the Physician Order Sheet (POS) for October 2013.

R8's Minimum Data Set (MDS) of 8/11/13 shows he has a Brief Interview for Mental Status (BIMS) score of 13 which shows no cognitive impairment. The MDS also shows R8 is totally dependent on 2 person physical assist for transfers and 2 person extensive assistance for repositioning. The MDS section for balance shows R8 is "only able to stabilize with staff assistance" for moving on and off the toilet. The MDS section for Range of Motion (ROM) codes R8 as a 2 for lower extremity mobility which documents an "impairment on both sides". The skin treatment section of the MDS showed R8 requires a turning and repositioning program. R8's care plan dated 7/1/13 under discharge care plan, documents "he requires assistance with all ADL's (activities of daily living) and is unable to propel himself in his wheelchair." The ADL care plan identified R8...
### SUMMARY STATEMENT OF DEFICIENCIES

<table>
<thead>
<tr>
<th>ID</th>
<th>PREFIX</th>
<th>TAG</th>
<th>PROVIDER'S PLAN OF CORRECTION</th>
</tr>
</thead>
<tbody>
<tr>
<td>S9999</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Continued From page 4

On 10/17/13 at 11:00 AM, R8 was brought to the conference room by a Certified Nursing Assistance in a bariatric manual wheel chair with bilateral foot/leg rests in the upper (extended) position. R8's legs were not positioned on the rests but were hanging loosely between the foot/leg rests. A mechanical lift transfer sling was under R8 in the chair. R8 stated this was not his wheelchair. R8 said he personally owns an electric wheelchair but the facility "apparently needs to evaluate me" to make sure I "need" an electric wheelchair. R8 said "I can't get around in this one. Someone has to take me everywhere." R8 appeared to have limited arm movement but did attempt to move his right leg by tugging at the top of his pant leg with his right hand to move the lower extremity to the right as if to put it on the leg rest. The right leg slid back to the central position. R8 had only socks to his feet. Both legs between the end of the pant leg and the top of the sock were dark purple in color with edema noted.

R8 stated he had not had restorative therapy in weeks because the facility was short of staff. R8 said when a CNA call's off, the CNA's from restorative are pulled to work the floor. R8 said the facility is so short of staff that the staff "take short cuts" and hurry to get things accomplished. R8 stated one example of a "short cut" was when he received a "gash" on his lower leg because the aides didn't remove the leg rests from the chair "before transferring me. I am on Coumadin (clot prevention agent) so they couldn't get it to stop bleeding." R8 stated the ambulance was called and he required 10 sutures to the wound in the emergency department and subsequent daily treatments/wound care.
R8's medical records/incident reports show R8 did sustain a laceration on 10/5/13 which required treatment/sutures at the local emergency room after his leg came into contact with the leg rest of a wheelchair during a mechanical lift transfer. The POS dated 10/13 showed R8 was ordered Coumadin 4.5 mg and Coumadin 5 mg daily in alternating doses. The 10/15/13 lab report showed R8's PT (Prothrombin Time) as 25.1 (normal range is 9.5-13) and an INR (International Normalized Ratio) was 2.3 (normal range is 0.8 - 1.1). These results show R8 is at a higher risk for bleeding concerns. R8 has no care plan to identify his potential for injury or bleeding risks.

During the 10/17/13 interview with R8, he also stated that he has had to sit in a soiled incontinent brief for an hour because there was not enough staff members working to assist him. R8 stated because he is transferred by use of a mechanical lift, 2 staff members are required to be present to transfer him. R8 stated when a CNA calls off and is not replaced, it leaves one CNA on the wing and that CNA must wait for someone else to become free from another assigned area before a mechanical transfer can be completed. R8 said the staff shortages result in extended wait times for toilet use, getting up for meals, laying down, going to the bathroom, and just a general "rush" to get cares completed. R8 could not give dates or times when he remained in his soiled garments. R8's MDS of 8/11/13 identified R8 as being continent of bowel with occasional bladder incontinence episodes. The care plan dated 8/20/13 with a revision of 10/17/13 documents R8 is to be given peri care after each incontinent episode by the CNA's.
On 10/17/13 at 10:00 AM, E2 (Director of Nursing) said she is in charge of the CNA scheduling. E2 said she schedules 2 nurses and 4 CNA's for the first and second shifts for each of the two floors and 1 nurse and 2 CNA's for each of the floors on the night shift. E2 said if someone calls off, in an effort to prevent overtime situations, she will pull one or both of the restorative CNA's to the floor to assist. E2 stated the facility has a CNA that works in the billing department she will pull if necessary. When asked at what point would replacements be called in to cover for the CNA's, E2 stated "if the numbers drop to 2 CNA's per floor on the day or evening shift, that; would not be allowed, so at that time someone would be called in." E2 verified if there were 3 per floor on the day and/or evening shift (1 below facility scheduling for each floor) the staff would work with those numbers without replacements.

Schedules were reviewed for 10/1/13 through 10/16/13. On 10/5/13, when R8 received his leg laceration, the incident report showed a nurse was assisting a CNA with his transfer. The 10/5/13 schedule showed the restorative CNA was pulled to the floor to cover duties, however, even with her assistance, the staffing fell below the facility's 4 CNA's per floor. On 10 of the 16 days reviewed, CNA's had been pulled from restorative and/or billing duties to cover the floor requirements. On 8 of the 16 days, the schedule showed no restorative CNA's. With use of the restorative and billing CNA's, the facility had 8 of 16 days where the CNA's still numbered 3 or below on one or both floors of the facility.

On 10/17/13 at 10:45 AM, R9 was asked about her cares. R9 stated she has had to sleep in soiled pants until someone could come. R9 said...
**STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION**

**A. BUILDING:**

**PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:** IL6008049

**B. WING:**

**DATE SURVEY COMPLETED:** C 10/24/2013

**NAME OF PROVIDER OR SUPPLIER:** ASTA CARE CENTER OF ROCKFORD

**STREET ADDRESS, CITY, STATE, ZIP CODE:** 707 WEST RIVERSIDE BOULEVARD ROCKFORD, IL 61103

<table>
<thead>
<tr>
<th>(X4) ID PREFIX TAG</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)</th>
<th>(X2) ID PREFIX TAG</th>
<th>PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)</th>
<th>(X5) COMPLETE DATE</th>
</tr>
</thead>
</table>
| S9999              | Continued From page 7 she is transferred by a mechanical lift and "2 staff have to do that”. R9 said she has had bowel movements in her pants waiting for enough staff to complete the transfer.  

On 10/16/13 at 11:40 AM and 12:00 PM, R5 and R4 were interviewed respectively. Both stated the facility is always short CNAs and cares are late or not given. Both residents stated when a CNA call's off, no one else is called in to replace them.  

R5 stated "today" (10/16/13) "I just got tired of waiting so I had to dress myself without help."  

R4 stated "my roommate (R8) has had to lay in his own feces."  

On 10/17/13 between 10:00 AM and 10:45 AM, E14, E16, E17 and E18 (CNA's) were interviewed.  

The following comments were made: "We work short a lot"; "Turns get missed"; "People wait longer than they should to get cares"; "We tell the residents they will have to wait and we will get back to them and it is 20 minutes or longer and they get upset"; "There is a delay in toileting, transfers of residents who require use of a (mechanical lift)"; "(R9) has wet and soiled herself waiting"; "(R13) left yesterday but he was always mad and yelling because he wasn't getting his turns"; "There is no time for extras like shaves, showers, cleaning nails, bedmaking, etc."; "When they pull the restorative CNA's we only have them for a limited time because they have work to do too"; "Passing water by 11:00 AM and obtaining vital signs for the nurse by 10:00 AM don't get done because we are assisting residents"; "If we don't get to the resident's on time they will try to do things themselves and then fall and we have a bigger mess" (R11 & R12 given as examples that will try to do tasks on their own and fall.) | S9999 |
<table>
<thead>
<tr>
<th>ID</th>
<th>PREFIX</th>
<th>TAG</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)</th>
<th>ID</th>
<th>PREFIX</th>
<th>TAG</th>
<th>PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)</th>
<th>COMPLETE DATE</th>
</tr>
</thead>
<tbody>
<tr>
<td>S9999</td>
<td></td>
<td></td>
<td>Continued From page 8</td>
<td>S9999</td>
<td></td>
<td></td>
<td>(B)</td>
<td></td>
</tr>
</tbody>
</table>