STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145821	A. BUILDING _____ B. WING _____	C 04/15/2015

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) COMPLETION DATE
F 000	INITIAL COMMENTS Investigation of complaints: 1571780/IL76225- F226, F323 1571757/Il76198-F372	F 000		
F 226 SS=D	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on interview and record review the facility failed to follow their policy and notify the Illinois Department of Public Health within 24 hours when a new fracture occurs in the facility for one resident (R1) in a total sample of three resident reviewed for abuse and neglect. Findings include: According to R1's face sheet and discharge sheet she was admitted to the facility on 11/11/14 and discharged 12/6/14. According to R1's hospital discharge record dated 11/11/14 states that on 11/6/14 she had a left distal fracture open reduction internal fixation. According to R1's progress note from orthopedic doctor dated 11/26/15 states "X-ray reveals a new	F 226		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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F 226	Continued From page 1 fracture above the original fracture. According to R1's document titled Rosewood Attending physician/consult progress note dated 11/26/14 indicated new oblique distal femur fracture. According to R1's document under Social Services dated 11/28/14 states POA(Power of Attorney) called and requested information regarding a fracture noted by the residents orthopedic doctor and was informed that the nursing department would be notified and someone would contact him and the ADON(Assistant Director of Nursing) was made aware. According to R1's document titled Compliment/Complaint Form dated 2/24/15, the POA requested a summary of the investigation regarding R1 and her injuries to her left leg and arm. Review of R1's discharged information and facility information shows that on 2/24/15 that a document titled Incident/Accident Report was initiated for the new fracture that was identified while R1 was in the facility on 11/26/14 and POA request information about from social services on 11/28/15. There are also document for R1 dated 2/24/14 titled "Fracture of Unknown Origin" and Incident Investigation" On 4/13/15 at 3:5 E1(Administrator) stated that there had been some confusion with the new fracture for R1 on 11/26/14 because if was so close to the original fracture. E1 stated it was the	F 226		

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F 226	Continued From page 2 facility policy to initiate an investigation and notify IDPH(Illinois Department of Public Health) any time there is a fracture that is identified within the facility. E1 stated she is in charge of any issue of possible abuse or neglect. E1 confirmed a new fracture of unknown origin should be considered an injury that is reported to IDPH within 24 hours. E1 confirmed no investigation was started on 11/26/14 for R1 and IDPH was not notified. E1 stated she was not aware of concerns voiced to social serviced with noted dated 11/28/14 and POA requesting information regarding new fracture. E1 confirmed she did not know about this and did not initiate an investigation or call IDPH. Asked E1 if she had notified IDPH when she had initiate and investigation to R1's fracture on 2/24/14. E1 stated she had not because she had been discharged. E1 stated they did not make IDPH aware of R1's fracture and that they should have. According to facility policy titled: "Abuse Investigation Policy" -Key Definitions 2. Timely Reporting- abuse allegations must be initially reported by the Administrator to the State Agency within 24 hours of occurrence except in cases where there is serious bodily injury resulting from a suspected crime. Where there is serious bodily injury resulting from a suspected crime the report must be made to the State Agency and local law enforcement immediately, but no later than two (2) hours after forming suspicion Follow up reporting to the State Agency is due no later than 5 days following the initial report date unless an extension is granted by the State Agency.	F 226		

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F 323 F 323 SS=D	Continued From page 3 483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review the facility failed to implement care plan safety precautions for one resident with seizure disorder (R3) and failed to transfer residents following facility policy. This applies to three residents out of three (R1, R2, and R3) reviewed for transfers and safety. Finding Include: 1. According to R3's document titled "Incident/Accident Report" dated 3/22/15, indicates R3 was found on floor around 4:25 am and was sent to the hospital and was found to have a fractured in her leg. According to R3's Care Plan Report with admit date of 2/1/15 she is requires maximum assistance with transfers, is at high risk for falls and is to have two full padded side rails up when in bed as seizure precautions to prevent injury. Also indicated that R3 was originally admitted on 2/1/15 for rehabilitation for fracture of arm from fall at home.	F 323 F 323		

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F 323	Continued From page 4 According to R3's Physicians Order Sheet for April 2014 she had contributing diagnosis of a Seizure disorder, leg fracture, she has an indwelling catheter and no weight bearing to right leg On 4/14/15 at 10:00 am E4 CNA (Certified Nursing Aide) was in R3 room and bed was in the highest position. There was no pad on the left side rail of R3's bed. E4 stated she was getting ready to transfer R3 and had to go get help because she was a two person transfer. E4 exited the room and R3's bed was in the highest position and there was no padding on left side rail per doctors orders. On 4/14/14, at 10:05 E4 returned with E5 CNA/RA(Certified Nursing Assistant/Rehabilitation Assistant). E4 and E5 proceeded to sit R3 up in bed. They then arranged her to be sitting on left side of bed and placed slide board to wheelchair on left side. E4 was on R3's right side and E5 was on R3's left side. During transfer of R3 to wheelchair, E5 grabbed the gait belt then the back of R3's pants to assist with the transfer. Also during transfer R3's right foot was noted to be pressed against the floor and resident yelled out in pain "ouch that hurts" Neither CNA noticed resident putting weight on right leg. On 4/14/14 at 10:15 Z2(family member) stated that he tried to come visit every day and he had seen several nursing assist grab R3 by the back of her pants the transfer her. Z2 stated R3 usually complained of discomfort with transfers and had a recent increase in pain medication due to increase in pain.	F 323		

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F 323	Continued From page 5 On 4/14/15 at 12:2, E9 LPN(Licensed Practical Nurse) stated he was the restorative and rehabilitation nurse and did the assessments for the side rails and worked with therapy to decide if residents needed assisting devices. E9 confirmed that R3 should have padding on rails if she is in bed for safety due to seizure history. E9 stated that grabbing the back of the resident pants is not the proper way to transfer and it could cause trauma and discomfort for a resident and specifically with R3 because she had a catheter it could become dislodged and that would be very traumatic and be very uncomfortable. E9 also stated that residents bed should never be in the highest position if a resident is in them especially if they are at high risk for falls. On 4/14/15 at 11:50 am, E3 ADON(Assistant Director of Nursing) confirmed that grabbing the back of residents pants is an improper methods of transferring and confirmed could lead to accident or injury to residents. On 4/15/15 at 9:10 am E2 DON (Director of Nursing) confirmed that grabbing the back of a residents pants is and improper method of transferring a resident. 2) According to the document identified by the facility as their current transfer list for the facility for 4/13/15, R2 requires one person to assist her with transfers. According to R2 mental status assessment dated 1/20/15 the score is 15 which is the highest score and shows impairment. On 4/15/15 R2's Assessment Coordinator stated R2's next assessment was today and she under	F 323		

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F 323	Continued From page 6 section G, Functional Status her transfer status would be that she would require the assist of one person with transfers due to increase weakness and increased need for assistance. Coordinator also stated R2 had a fall this past weekend (4/11/15) so she was also a high fall risk also. According to document with initiation date of 4/11/15, R2 had a fall on that day at 7:45 am without serious injury. On 4/14/15 R2 was asked if she needed help with transfers. R2 stated she had to have help and only needed one person. R2 stated she had been sick recently and had been very weak and needed more help. Asked R2 how staff transferred her. R2 stated that usually just one staff member transfers her. R2 went on to add that the aids use a belt with one hand and then grab the back of my pants with the other hand to pull me up and back in the chair. R2 stated that E7 and E8 (Nurse Aids) transferred her like that and she stated "Oh yes they are my regular nurses aides." 3. According to R1's medicare assessment with date of 11/25/15 under sections G functional status R1 required extensive assistance of two persons with transfers in bed and to chair/wheelchair. According to document for R1 titled Compliment/Compliant Form dated 11/28/14 under complaint states "daughter requesting for CNA(Certified Nursing Assistant) (E11) not be assigned to her mother." states "family uncomfortable with the CNA, unsure of his abilities." States that once they heard R1 say "ouch" during a transfer. No allegations of abuse, just unsure of his abilities."	F 323		

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F 323	Continued From page 7 On 4/10/15, Z1(family member) stated that while R1 was in facility he had seen E11 CNA transfer R1 by himself. Z1 also stated that it was also observed that E11 had transferred R1 by himself and had grabbed the back of her pants to transfer into her wheelchair. Z1 stated that R1 had made comment that E11 did that often and it was very uncomfortable. Z1 stated R1 did not want to say anything because she did not want to be a bother.	F 323		
F 372 SS=C	483.35(i)(3) DISPOSE GARBAGE & REFUSE PROPERLY The facility must dispose of garbage and refuse properly. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review the facility failed to maintain their garbage dumpster in a manner to maintain cleanliness. This has the potential to affect all 104 resident. Findings Include: On 4/13/15 at 8:45 am on of the fallibility's dumpster lids was open and three bags of trash on ground around dumpster. On 4/13/15 at 5:30 PM one of the facility's dumpster lids was open. On 4/14/15 at 11:00 am one of the facility's dumpster lids was open. There were over 10 pieces of white paper on the ground, over 10 pieces of pink paper on the ground. There were two small bags of trash next to the trash can.	F 372		

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F 372	Continued From page 8 On 4/14/15 at 4:50 PM one of the facility's dumpster lids was open. There was a large trash bag on top of the dumpster and 4 large bags on the ground beside the dumpster. There were over 10 pieces of paper on the ground around the dumpster. On 4/14/15 at 3:55 PM, E12 (Custodian) stated that it was his responsibility to make sure the dumpster was taken care of and the area was cleaned. On 4/14/15 at 4:1, E1(Administrator) state the dumpster lids should remain closed as well as the gate. Also stated that there should note be anything on top of dumpster and there should not be anything on ground around it and all trash bags should be inside of it. According to the facility's policy titled "Maintenance Service: General Polices" states under "Grounds: A- Maintenance shall be responsible for keeping our grounds free of litter" According to the facility Census sheet dated 4/13/14 the census for the facility on that day was 104	F 372		