DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145891	A. BUILDING ______ B. WING ______	02/05/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROSEWOOD CARE CENTER OF ROCKFORD	**1660 SOUTH MULFORD ROCKFORD, IL 61108**

(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 Annual Licensure and Certification Survey Complaint Investigation #1510582/IL74712 - F225, F312, & 300.1210d)3) cited	F 000		
F 221 SS=D	483.13(a) RIGHT TO BE FREE FROM PHYSICAL RESTRAINTS The resident has the right to be free from any physical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review the facility failed to reassess the use of a restraint for a resident who had a condition change. The facility failed to have release times when using a seatbelt restraint. This applies to 1 of 3 residents (R3) reviewed for restraints in the sample of 15. The findings include: The Minimum Data Set (MDS) assessment of 1/12/15 shows R3's cognitive status is severely impaired. On 2/3/15 at 7:45 AM, 9:10AM, 11:00 AM, R3 was in her room sitting in her reclining chair with a wedge cushion and a seatbelt secured around her waist. On 2/3/15 at 12:40 PM, R3 was in her room sitting in a reclining chair with a wedge cushion and a seatbelt secured around her waist, while a staff member was feeding her. At 2:00 PM, R3 remained in a reclining chair with the wedge cushion and seatbelt on.	F 221		

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

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 221	Continued From page 1 The Care Plan dated through April 2015 shows R3 has a wedge cushion in her Broda chair with a self release seat belt .... (no release times for the seatbelt are identified). The Assistive Device/Restraint Review report shows R3 was last reassessed for a wedge cushion and self release belt on 1/26/15. On 2/2/15 at 1:10 PM, E8 (Certified Nursing Assistant-CNA) stated, " R3 has declined significantly the last 3-6 months. R3 used to try to get out of the bed, but not anymore. These days she is total dependent on everything." On 2/3/15 at 2:00 PM, E10 (CNA) stated, " At one point she used to get up, now she doesn't. The seatbelt should probably be discontinued." On 2/3/15 at 12:00 PM, E7 (Restorative Nurse) said, the seatbelt should be released when she is not in the Broda chair. On 2/4/15 at 10:30 AM, E7 said, R3 was reassessed today. R3 has declined since last assessment ....The seatbelt and wedge cushion got discontinued today. The facility's Assistive Device/Restraint Assessment Policy dated February 2009 states, " ...Monitor the resident. The staff must determine if the assistive device/restraint is safe for the resident and be observant of any decline in the resident's physical functioning related to restraint usage. Significant decline requires reduction or elimination of the assistive device/restraint and/or reassessment of the appropriateness of the device/restraint ...Release restraints periodically for exercise, toileting, and positioning or during times when the resident is being closely supervised.	F 221		
F 225 SS=D	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS	F 225		

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F 225	Continued From page 2 The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by:	F 225		

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F 225	Continued From page 3	F 225		

Based on observation, interview and record review the facility failed to thoroughly investigate bruising from an unknown origin.

This applies to 1 of 4 residents (R10) reviewed for abuse.

The findings include:

The facility's incident/accident report for R10 dated 1/11/15 documents, "During AM's CNA [Certified Nursing Assistant] observed a bruise purplish/bluish in color on right deltoid and under armpit to side of upper chest." The report shows 3 staff were interviewed, 2 CNA's and a nurse all on 1st shift. No other staff were interviewed and no other residents on that assignment were interviewed.

Z5 was not interviewed but gave an account on 2/3/15 at 9:10am of staff sometimes using the lift or sometimes just lifting R10 under the arms. The facility's statement summary was inconsistent with reports given from Z1, Z3 and Z5. None of these people were interviewed as part of the investigation.

The MDS (Minimum Data Set) dated 11/1/14 shows, R10 has severe cognitive impairment and requires extensive assistance of 2 staff for transferring. The assessment shows R10 is incontinent of bowel and bladder.

R10's Physician's Order Sheet dated 1/14/15 documents, "Bruise of unknown origin to the right deltoid/right axilla."

On 2/3/15 at 8:10AM Z1 said, "They are supposed to use the [mechanical lift] but they

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F 225	Continued From page 4 didn't and [R10] ended up with a bruise under her arm." On 2/3/15 at 2:20PM, Z3 said R10 had a bruise under her armpit and breast it looked like it may have been from transferring her because her arms are rigid. It could have been from sitting her on a shower chair. They have a lot of new staff. On 2/3/15 at 9:30AM, during skin check with E6 (LPN), E6 said R10 has a bruise (outlined with her finger) around the top of the arm and on the right breast "You can see now it is yellow and fading." On 2/4/15 at 11:10AM, E2 (RN-DON) said the bruise was noticed on the 1st shift during care by the CNAs. E2 said she only interviewed 2 CNA's that work on the 1st shift. She did not interview anyone else. The abuse investigation policy's definitions related to abuse documents, Injuries of unknown origin are injuries that not observed by any person and the injury could not explained by the resident. The injury is suspicious because of the location, an area not generally vulnerable to trauma. All incidents involving potential abuse will be investigated.	F 225		
F 241 SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.	F 241		

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F 241	Continued From page 5 This REQUIREMENT is not met as evidenced by: Based on observation and record review the facility failed to ensure staff provide care in a respectful manner by responding to a resident requests. This applies to 1 resident (R17) in the supplemental sample reviewed for dignity. The findings include: On 2/3/15 at 11:10am, R17 wheeled up to the 100/200 nurse's station. R17 said in a loud voice that she wanted a snack. R17 said, "I want some cheese and crackers. Does nobody hear me? I want a bag of potato chips. I've got money and I can get a bag of potato chips." R17 wheeled herself back to her room without being spoken to or acknowledged. There were four staff seated at the desk and other staff that passed by without assisting R17 to get a snack. The facility's Residents Rights booklet for People in Long Term Care facilities shows, "Your facility must make reasonable arrangements to meet your needs and choices."	F 241		
F 312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene.	F 312		

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F 312	Continued From page 6 This REQUIREMENT is not met as evidenced by: Based on observation, internveiw, and record review the facility failed to ensure a resident's skin was cleansed after urinary incontinence, failed to ensure a resident's mouth was cleaned and free of food debris, and failed to change a residents soiled clothing. This applies to 1 of 6 residents (R10) reviewed for Activities of Daily Living in the sample of 15. The findings include: R10's January, 2015 Physician's Order Sheet documents that R10's diagnoses include Alzheimer's Dementia, Cerebral Vascular Accident, Parkinson 's disease, and Urinary Tract Infection. R10's Minimum Data Set (MDS) assessment of 11/1/14 shows that R10 has severe cognitive impairment and requires extensive assistance of one person for hygiene. The same assessment documents that R10 is incontinent of urine and requires extensive assistance of one person for toilet use. R10 is at risk for skin breakdown. On 2/3/15 at 9:20 AM, E12, Certified Nursing Assistant (CNA) and E13 (CNA) transferred R10 from her recliner into her bed. E13 removed a saturated incontinent brief. R10's urine had a very strong ammonia odor. E13 assisted R10 onto her side so a skin observation could be made. R10 had some peeling skin and a discoloration on the left buttock. A small open area was observed at the crease of the R10's buttock. E13 did not wash R10's peineal area before she placed a clean incontinent brief under R10 and began to secure the sides, then went to get the nurse to apply cream to R10's buttocks. E6, Licensed Practical Nurse (LPN) entered the room, and applied cream to R10's buttocks. E13	F 312		

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F 312	Continued From page 7 and E6 were questioned regarding the cleansing of R10's skin after urinary incontinence. E6 said that R10's incontinent brief was not wet. E13 said it was and picked up the wet brief she had placed on the night stand and showed it to E6. E6 said " Oh we can wipe her off. She is hospice and she has a lot of UTI's (Urinary Tract Infections). We don't check her for them anymore. " R10 was seen by Z2 on 2/4/15. Z2's progress note shows that R10 has irritation to her buttocks that was diagnosed as Incontinence Associated Dermatitis. At 9:20 AM R10 was observed laying in her bed. Her mouth was partially open and her lips were dry and cracked. R10's lower teeth had a coating of food debris. R10 was observed wearing a pair of tan slacks that were stained with a dark color at 9:00 AM and again when she was up gotten up for lunch at 11:15 PM. According to the Incontinence Care Policy dated 6/2008, cleansing will be provided after each episode of incontinence to prevent skin breakdown. The policy for Morning Care dated 11/1998 shows that mouth care should be provided as part of the AM care.	F 312		
F 318 SS=D	483.25(e)(2) INCREASE/PREVENT DECREASE IN RANGE OF MOTION Based on the comprehensive assessment of a resident, the facility must ensure that a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion.	F 318		

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F 318	Continued From page 8 This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review the facility failed to apply hand rolls to a resident with contractures of her hand. This applies to 1 of 4 residents (R10) reviewed for range of motion in the sample of 15. The findings include: R10's January, 2015 Physician's Order Sheet documents that R10's diagnoses include Cerebral Vascular Accident, Parkinson's disease, and Alzheimer's disease. R10's Minimum Data Set (MDS) assessment of 11/1/14 shows that R10 has severe cognitive impairment, and range of motion limitations of both upper and lower extremities. Physician's Order Sheet (January, 2015) shows an order for hand rolls to be placed in R10's hands at 7:00 AM and removed at bedtime. E2 Director of Nursing (DON) said on 2/4/15 at 10:45 AM, that R10 has limited range of motion, and contractures. R10's Care Plan for Activities of Daily Living dated through 2/5/15 documents that R10 is totally dependent on staff for care. R10 is to have rolled washcloths in bilateral hands daily that are to be removed at bedtime. R10 was observed in her bed on 2/3/15 at 9:20 AM, R10's arms, hands, and legs, were contracted. The facility Contracture Policy dated 6/2008 documents that contractures will be accurately identified to ensure that the appropriate interventions are implemented to maintain optimal function or to prevent decline.	F 318		
F 365 SS=D	483.35(d)(3) FOOD IN FORM TO MEET INDIVIDUAL NEEDS	F 365		

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F 365	Continued From page 9	F 365		

Each resident receives and the facility provides food prepared in a form designed to meet individual needs.

This REQUIREMENT is not met as evidenced by:
Based on observation, interview, and record review the facility failed to ensure a resident that required nectar thick fluids received the correct consistency.
This applies to 1 of 4 residents (R10) reviewed for swallowing problems in the sample of 15.
The findings include:
R10 ' s January, 2015 Physician ' s order sheet documents that R10 ' s diagnoses include Cerebral Vascular Accident, and Parkinson ' s disease. The same order sheet shows that R10 is on a General Diet, Pureed Consistency, and Nectar Thick Liquids.
R10 ' s Minimum Data Set (MDS) assessment of 11/1/14 documents that R10 requires extensive assistance of 1 person for eating.
R10 ' s Diet Order Sheet documents that R10 is on a General Diet with Fortified food, whole milk, extra margarine, cheese, sour cream, and Nectar Thick Liquids.
The Dietary Progress Note dated 1/26/15 documents that R10 has Parkinson ' s Dysphagia, and Advanced Dementia. R10 is receiving General Pureed diet and Nectar Thick Liquids.
R10 ' s Care Plan for Nutrition dated through 2/5/15 shows that R10 is on a puree diet with nectar thick liquids.
The approaches include providing R10 with nectar thick liquids; ensure resident is sitting up at 90 degrees for feeding.

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F 365	Continued From page 10 R10 ' s Team Care Plan (Hospice) dated 1/19/15 documents that R10 is on aspiration precautions. On 2/3/15 at 9:00 AM E13 Certified Nursing Assistant (CNA) was feeding R10 breakfast. R10 ate oatmeal and drank cranberry juice, (not thickened) an unopened carton of whole milk was left on the tray. At 11:15 AM E9 (CNA) was feeding R10 and giving her whole milk with a straw. E9 said that there was only one resident on the wing that was on thickened liquids. (Not R10) E6 Licensed Practical Nurse (LPN) was asked if R10 was asked if R10 was supposed to receive thickened liquids and she said yes. E6 said that R10 was on Nectar Thick Liquids. E6 was made aware that R10 had received regular liquids at breakfast and now again with her lunch. R10 ' s Nursing Notes for 2/3/15 at 2:30 PM documents that R10 received thin liquids during her meal.	F 365		
F 371 SS=F	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on Observation and Interview the facility failed to ensure the sanitizing solution in a	F 371		

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F 371	Continued From page 11 cleaning bucket had the required concentration of sanitizer. The facility failed to ensure that dishes were clean, such as large plates, small plates and bowls. The facility failed to ensure that dry storage items that had been opened were secured shut and dated with an " opened on " date. This affects all 68 residents living in the facility. The findings include: The CMS 672 (Resident Census and Condition Sheet) dated 2/3/15 shows a census of 68 residents. On 2/2/15 at 10:25AM., E4 (Dietary Supervisor) tested the " salad sink " sanitizer bucket, and it did not register any ppm (Part Per Million) of sanitizer. E4 stated that the sanitizer buckets are to register between 100 and 200 ppm on the Quaternary Ammonium test strip. E4 is unsure why this particular bucket did not register. E4 also stated that the sanitizer buckets are to be changed out every 2 hours. On 2/2/15 at 10:35AM, five dishes each of large plates, small plates and bowls on the dish holder were checked for cleanliness. Five large plates were soiled, five small plates were soiled and three bowls were soiled. E4 stated that he did not understand why these dishes were soiled. On 2/2/15 at 11:30AM, the dry storage had multiple containers (rice, cereal, pasta) that were opened, undated, and were not secured tightly shut. E4 stated that this was not acceptable to have open containers of food because it might lead to rodent infestation.	F 371		
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an	F 441		

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F 441	Continued From page 12 Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record	F 441		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROSEWOOD CARE CENTER OF ROCKFORD	**1660 SOUTH MULFORD ROCKFORD, IL 61108**

(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 441	Continued From page 13 review the facility staff failed to wash their hands after providing care and remove contaminated gloves to prevent the spread of infection. This applies to 1 of 12 residents (R10) reviewed for infection control in the sample of 15 and 1 resident (R18) in the supplemental sample. The findings include: 1. On 2/2/2015 at 10:00AM, E1-Administrator stated that all residents on the 100 and 200 wings of the facility are being isolated in their rooms due to a Norovirus outbreak. On 2/4/2014 at 9:20 AM, in R18's room, E11 Certified Nursing Assistant (CNA) assisted R18 to the bathroom using a mechanical lift. E11 used multiple disposable wipes to clean R18 of stool and urine. E11 did not remove her contaminated gloves or wash her hands after cleaning R18. Wearing the same contaminated gloves, E11 then touched multiple surfaces (E18's pants, mechanical lift sling, reclining geri chair, mechanical lift, E18's arms, and E11's own pants) and then removed her gloves. On 2/4/2014 at 9:20 AM, E11 stated that there were multiple employees infected with the norovirus and she too, had got it, but it happened on her weekend off so she didn't miss any work. The facility's Infection Control: Handwashing policy dated 4-2011, states, "Times to perform hand hygiene: before and after assisting a resident with toileting and after contact with body excretions". 2. R10's January, 2015 Physician's Order Sheet documents that R10's diagnoses include Cerebral Vascular Accident, Alzheimer's Disease and Parkinson's Disease. On 2/3/15 at 9:20 AM, E12, Certified Nursing Assistant (CNA) and E13 (CNA) transferred R10 from her recliner into her bed. E13 removed a saturated incontinent brief and placed it on the	F 441		

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F 441	Continued From page 14 night stand. E13 (wearing the same gloves) touched R10's clothing and blankets. E13 partially removed her gloves (rolled them down to the wrist/fingers) and left the room in search of E6 (LPN). E13 did not remove the gloves and wash her hands prior to leaving R10's. E6, Licensed Practical Nurse (LPN) entered the room, put on gloves and applied cream to R10's buttocks. Prior to removing the gloves, E6 touched R10's shoulder, and the privacy curtain.	F 441		