STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145846	A. BUILDING _____ B. WING _____	C 01/26/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROSEWOOD CARE CENTER OF EDWARDSVILLE	**6277 CENTER GROVE ROAD EDWARDSVILLE, IL 62025**

(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 Complaint #1740356/IL91170	F 000		
F 323 SS=G	483.25(d)(1)(2)(n)(1)-(3) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES (d) Accidents. The facility must ensure that - (1) The resident environment remains as free from accident hazards as is possible; and (2) Each resident receives adequate supervision and assistance devices to prevent accidents. (n) - Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements. (1) Assess the resident for risk of entrapment from bed rails prior to installation. (2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation. (3) Ensure that the bed's dimensions are appropriate for the resident's size and weight. This REQUIREMENT is not met as evidenced by: Based on observation, record review and interview, the facility failed to provide supervision to prevent falls for 1 of 3 residents (R2) reviewed for falls in the sample of 9. This failure resulted in R2 falling and sustaining a left-sided intraparenchymal hemorrhage, bilateral small	F 323		

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 323	Continued From page 1 subdural hematomas, traumatic subarachnoid hemorrhage, left parietal lobe contusion and left eye contusion that required emergency treatment and hospitalization. In addition, R2 had surgical placement of a gastrostomy tube and surgical revision of the ventriculoparetoneal shunt in R2's head after R2 deteriorated from ventricular enlargement. As a result of this latest fall, R2 can have nothing by mouth, no longer participates in restorative ambulation program and is restricted when seated in a wheelchair, with a full lap tray. Findings include: R2's Physician's Order Sheet (POS) for 1/2017 documents diagnoses, in part, as Altered Mental Status, Trauma, Subdural Hematomas Without Loss of Consciousness, General Muscle Weakness, Cerebrospinal Fluid Drainage Device, Ventricular Peritoneal Shunt Status, Dysphagia and Malnutrition. R2's Minimum Data Set (MDS), dated 10/12/2016, documents R2's Brief Interview of Mental Status (BIMS) Score was 9, indicating moderately impaired with cognition. The MDS documents she requires extensive assistance of two staff persons for transfers and ambulation, and has unsteady sitting and standing balance. The Incident/Accident Report for R2, dated 12/15/2016, at 7:30 PM, documents, in part, "Lost balance while ambulating with one assist. Resident (R2) has a history of self transfer attempts. Resident is 2 assist and employee (E12, Certified Nurses Aide, CNA) was one assisting resident (R2). Post Investigation Actions-staff discipline."	F 323		

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F 323	Continued From page 2	F 323		

E12's, CNA Incident/Accident Witness Statement, dated 12/15/2016 at 7:25 PM, documents, in part, "Was using walker to transport (R2) to the toilet. (R2) lost her footing and tried to grab her by the gait belt to pull her back up, and she fell hard and fast." The Report documents R2 sustained redness to the left back area.

R2's Care Plan, updated 12/15/2016, documents R2 received a pureed diet, with nectar thickened liquids and was on a restorative ambulation program with the assistance of 2 staff. R2's Care Plan of 12/15/2016 documents R2 was at risk for falls related to attempts to ambulate and transfer without assistance, with poor safety awareness.

The Incident/Accident Report for R2, dated 1/08/2017, at 7:55 PM, completed by E4, Licensed Practical Nursed (LPN) documents, in part, "This nurse heard a noise, looked out in the hallway and saw (R2) laying on her face in a pool of blood."

The Fall Investigation, dated 1/08/2017, documents "Resident is impulsive and yelling out this evening. Resident has diagnosis of anxiety. Has a recliner in room and at times, tries to stand from it. Resident (R2) sent to the hospital and admitted. Nurse was one on one care starting at 6:15 PM due to impulsive behavior. Nurse uncomfortable leaving resident in room due to resident history and current behavior. Stood up from wheelchair due to impulsive behavior. Nurse (E4) placed resident, wheels locked along the wall next to room 208, while she cared for that resident (in room 208). This is when resident (R2) stood up and fell." The Incident/Accident Report for R2 on 1/08/2017 does not document if R2 had a safety alarm on her wheelchair, or if it was

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F 323	Continued From page 3	F 323		

sounding.

A Incident/Witness Statement,dated 1/08/2017 at 8:00 PM, from E11, Certified Nurses Aide (CNA) documents, in part, that E11 did not witness the fall, but "the resident was in the hallway near the nurse by her cart", when E11 was asked where she last observed R2. E11 documented, "I had the alarm on her wheelchair, but it must have fallen off, or she took it off because she (R2) was acting crazy."

On 1/24/2017 at 2:55 PM, E4 stated, "Previously, the CNA asked me if I would watch her, and I said yes. Can't remember her name. She (R2) had been trying to get up out of the wheelchair. I brought her with me everywhere I went. I was in hallway 200, in front of another resident's room passing medication. (R2) was sitting in a wheelchair. I went into the room of another resident and talked to him and when I came back out (R2) was sitting in the wheelchair. I went back into his room to show him the MAR (Medication Administration Record) and thats when I heard a boom. I leaned over, and I could see the wheelchair, partially. She was laying there. I moved her. Her eyes started to roll, but she never did lose consciousness. She was yelling, 'My head, my head!' She injured the left side of her forehead. The alarm was sounding on the wheelchair. (R2) was not on official one to one observation. I just agreed to watch her. Another CNA gave me a towel. I applied pressure. Staff dialed 911." E4 stated, "The first time I ever took care of her. I got no report about her when I got there. She had a caregiver or family member sitting with her. She could stand and bear weight, but did not have a steady gait." E4 reported R2 had no gastrostomy tube at that time. E4 reported

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R2 had been out of her sight when she was giving medication to the other resident. E4 reported she is an agency nurse.

On 1/24/2017 at 4:00 PM, E2, Director of Nursing (DON) reported E4 had no specific orders for 1 on 1 observation for R2. E2 stated, "It is a nursing decision. I expect them to be in someone's sight at all times. We don't have a policy or procedure for 1 to 1 observation."

R2's hospital record, dated 1/09/2017 at 6:59 AM, documents R2 was air lifted to a more critical care hospital after being taken to a local hospital on 1/08/2016, due to her altered mental status with a slow response time.

R2's Post-Acute Care Transfer Report, dated 1/09/2017 documents R2's head CT (computed tomography) scan done on 1/08/2017 at 8:30 PM documents "multiple intracranial injuries, including a left temporal contusion, small subdural hematomas and traumatic subarachnoid hemorrhage. On admission, her (R2) CT scan demonstrated ventricles that were stable in size, with a prior CT performed when she was at her baseline. Later on during her admission, she underwent a routine followup head CT scan for evaluation of her traumatic injuries, which demonstrated ventricular enlargement. She would open eyes. She would not follow commands, and she would groan, this was off her baseline, which is where she is oriented to name, and at times can tell where she was located. Based on these findings, we proceeded to the operating room after obtaining informed consent for revision of her right ventriculoatrial shunt."

R2's Physician Discharge Summary/Orders from

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the hospital, dated 1/16/2017, documents, in part, "(R2) was evaluated by speech therapy who recommended a modified barium swallow which demonstrated that her swallowing mechanism is abnormal. Speech therapy recommended NPO (nothing by mouth). On 1/13/2017, the patient was taken to the OR (operating room) and had a PEG (percutaneous endoscopic gastrostomy) placement."

The Nurse's Note for R2 dated 1/16/2017 at 2:30 PM, documents, in part, "Resident readmitted to (resident room). 22 sutures noted to right scalp. Approximately 8 sutures noted to left scalp with scabbed area direct on top. Fading bruise noted to right neck, multiple bruises noted to bilateral upper extremities at various stages. G-tube (gastrostomy tube) site new, intact. Uses low bed with mat on floor, sensor alarm to recliner, (mechanical lift) to transfer, NPO (nothing by mouth) at this time."

On 1/20/2017 at 4:07 PM, R2 was in bed asleep. A fall mat was next to the bed. The head of R2's bed was raised 30 degree. R2's hair had been shaved. A healing and scabbed, large laceration was on R2's forehead. R2 had dark bruising to the left upper cheek and left orbit area. A large surgical scar was on the right side of R2's head above the right ear. There were no siderails on R2's bed. A bagged enteral feeding solution was connected to a gastrostomy tube in R2's abdomen and was draining by gravity.

On 1/24/2017 at 8:25 AM and 9:17 AM, R2 was up in a wheelchair with a full lap tray. R2 kept her head down and her eyes closed, unless she was spoken to. Then, R2 would only answer with a few words or not at all. At 9:25 AM, R2 was

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transferred to bed from the wheelchair by E7 and E8, CNA's using a mechanical lift. R2's body was flaccid and required the total assistance of E7 and E8 to position and turn R2 in bed. R2 was positioned on her back with her heels floated on a pillow. On 1/24/2017 at 1:12 PM, R2 remained asleep and in the same position.

On 1/25/2017 at 8:10 AM, 8:25 AM and 8:47 AM, R2 was up in the wheelchair with her eyes closed. A full lap tray was on the wheelchair preventing R2 from rising from the chair. When attempting to talk with R2 at 8:47 AM, R2 opened her eyes, but did not verbally respond, then closed her eyes. R2 was sitting on a mechanical lift pad.

R2's current Care Plan, updated 1/17/2017, documents, in part, "Interventions-Utilize full lap tray related to unsafe attempts to transfer self, and (mechanical) lift transfer." R2's restorative nursing program for ambulation has been discontinued.

On 1/25/2017 at 9:30 AM, E1, Administrator was discussing R2's fall of 1/08/2017 and stated, "She (R2) was out of sight. She was declining prior to this. She has a history of manic episodes and cycles through them."

On 1/25 and 1/26/2017, multiple attempts to contact Z3, Physician were unsuccessful.

The facility's policy and procedure, dated 9/2003 and entitled, "Fall Risk Assessments" documents, in part, "When significant potential for falls is noted via the assessments, appropriate fall prevention measures will be implemented."

The facility's policy and procedure, dated 2/2003

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F 323	Continued From page 7 and entitled, "Incident/Accidents" documents, in part, "(Facility's name) will take every precaution to prevent the occurrence of accidents."	F 323		