STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6014633	A. BUILDING: _____ B. WING _____	03/01/2019

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ROSEWOOD CARE CENTER OF INVERNESS	1800 COLONIAL PARKWAY INVERNESS, IL 60067

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S 000	Initial Comments Annual and Recertification Statement of Licensure Violations	S 000		
S9999	Final Observations 300.610a) 300.1210b) 4)5) 300.1210d)6) 300.3240a) Section 300.610 Resident Care Policies a) The facility shall have written policies and procedures governing all services provided by the facility. The written policies and procedures shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee, and representatives of nursing and other services in the facility. The policies shall comply with the Act and this Part. The written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, documented by written, signed and dated minutes of the meeting. Section 300.1210 General Requirements for Nursing and Personal CareThese requirements were not met as evidenced by: 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. Restorative measures	S9999	**Attachment A** **Statement of Licensure Violations**	

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shall include, at a minimum, the following procedures:
4) All nursing personnel shall assist and encourage residents so that a resident's abilities in activities of daily living do not diminish unless circumstances of the individual's clinical condition demonstrate that diminution was unavoidable. This includes the resident's abilities to bathe, dress, and groom; transfer and ambulate; toilet; eat; and use speech, language, or other functional communication systems. A resident who is unable to carry out activities of daily living shall receive the services necessary to maintain good nutrition, grooming, and personal hygiene.
5) All nursing personnel shall assist and encourage residents with ambulation and safe transfer activities as often as necessary in an effort to help them retain or maintain their highest practicable level of functioning
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.

These requirements were not met as evidenced by:

Based on observation, interviews and record

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reviews the facility failed to follow the resident transer policy procedure, for R12 one of residents reviewed for accidents and incidents in a same of 21. The improper transfer using a mechanical lift resulted in R12 sustaining right and left ankle fractures. R12 was immediately sent out to the hospital for treatment.

Findings include:

On 2/26/19 at 2:30pm visited R12 in her room. R12 was sitting in bed watching television. R12 talked about attending activities, food and activities of daily living (ADL) care. Resident stated she gets help from certified nursing assistants (CNA) when she need it. Resident talked about a fall she experienced. R12 said "I broke both of my ankles when I slid out of the wheel chair". R12 denied being in pain at this time but she could not recollect when the incident happened. R12 noted to be wearing heel protector boots on both feet.

A review of facility's fall investigation for R12 with incident date of 10/21/2018, documents R12 stated she slid off the wheelchair. V12 CNA transferred R12 from bed to wheelchair using the mechanical lift without any staff assistance.

A review of R12's resident care card shows weight bearing restriction bilateral lower extremity, bed mobility assist of 2, transfer total lift, non-ambulatory. R12's facility face sheet dated 2/27/19 shows R12 is a 65 year old person with diagnoses to include; hemiplegia, muscle weakness, abnormality of gait and mobility, muscle wasting and atrophy. R12's minimal data set (MDS) dated 10/1/2018 section "G" documents: "R12 is totally dependent, requires two or more person assist with transfer between

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surfaces including from bed to wheelchair.

A review of R12's plan of care dated 8/28/2018 and 12/3/2018 documents that R12 has care deficits and needs extensive assistance with bathing, hygiene, dressing, grooming, toileting, bed mobility and total assistance with transfer due to diagnosis of dementia, history of CVA (Cerebral Vascular Accident", neuropathy, depression and weakness, interventions include to assist as necessary to transfer. Mechanical lift for transfers.

R12's hospital records and radiology exam dated 10/22/2018 documents x-ray of right ankle, history of fall, 2 views are obtain showing fractures of distal tibia fibula. Impression: distal tibia and fibular fractures, left ankly x-ray history of fall, 2 views obtained, the bones are osteopenic, there are diffuse vascular calcification, faint luency ankle mortise appears intact, no other further evidence for fracture. Impression: faint luency over the medial malleolus could be a fracture and needs clinical correlation.

R12's hospital records consultation report dated 10/23/18 shows reason for consultation; bilateral ankle fracture clinical impression and recommendation right distal tibia fractured with angulation, left non displaced extra articular medial malleolar fracture.

On 2/27/19 at 9:42am V2 (DON-Director of Nursing) said, "R12 sustained an ankle fracture after sliding from wheelchair when V12 (CNA providing care for R12) inappropriately transferred R12 to wheelchair using a mechanical lift. It should have been two persons or more using a mechanical lift to do this transfer. There

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is a risk for an accident. No staff should transfer a resident with a mechanical lift along."

During the survey of 2/26/19-2/28/19, V12 CNA was not available for interview.

ON 2/28/29 at 12:21pm V13 Registered Nurse stated on the day of incident in October 2018, another staff memeber came to her and told her that R12 was on the floor and needed help V13 stated when she went to R12's room, R12 was sitting on the floor and V12 was there with the mechanical lift. V12 stated V12 told her that he attempted to transfer R12 to the wheelchair using the mechanical lift. He stated he was able to halfway place her in the chair but could not reposition her when she slid to the floor. V13 stated V12 told her that he left the room to get help to reposition R12 in wheel chair safely. V13 said she does not remember any more details of the incident. At this time V13 did not comment that she completed a nursing assessment or assess for pain. V13 said CNAs V16, V15 and V12 were present at the time.

V16 and V12 were not available for interviews. However V15 was available for an interview.

On 2/28/19 at 2:40pm V15 stated that he does not remember any details from the incident related to R12.

A review of V12's statement dated 10/22/18 documents V12 transferred R12 from bed to her wheelchair using mechanical left. When the resident was on the wheelchair, she was slouching. V12 told the resident he will be right back then left to find another staff to help him reposition the resideent. As soon as he walked out the resident slid out of her chiar, another CNA

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S9999	Continued From page 5 called the nurse. A review of facility incident investigation completed by V2 DON dated 10/22/18 documents type of incident fall, R12 is alert and oriented 2-3, R12 started complaining of pain to both (B) ankles 10/22/18. R12 was sent to the hospital, investigation type: fall. V2 identified (B) to mean both. investigation conclusion; etiology of incidenet determined as R12 slid off wheelchair after V12 transferred R12. V12 left resident's room to get someone to help him reposition R12. A review of the facility preliminary incident investigation for R12 dated 10/21/18 documents on 10/21/18 at 11:00 am R12 was observed on the floor on side lying position. Stated that she slid off the wheelchair. Denied any pain at that time. No obvious injury. On 10/22/2018 at 9:00 am R12 started complaining of pain in bilateral ankles. Nurse gave pain medicine. When nurse reassessed, resident was stil aving pain, unable to do Range of Motion (ROM) with internal rotation of both feet. MD (Medical Doctor) notified. R12 sent to local hospital for evaluation. Power or Attorney notified. At around 5:00 pm received call from local hospital. R12 being admitted with didtal tibia and fibular fracture. A review of facility's Resident Abuse investigation report for R12 dated 10/30/2018, shows date of incident 10/21/18 at 11:00am, resident injured box is checked for yes, desciption shows distal tibia and fibual fracture, resident sent to local hospital for evaluation and treatment, based on interviews conducted the facility determined that the CNA transferred R12 from bed to wheelchair using mechanical lift by himsef which resulted to resident falling. R12 did not show any signs of injury nor complain of pain until the following day,	S9999		

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R12 was then sent to hospital as soon as injury was observed. One CNA was terminated for not following facility protocol on mechanical lift transfer.

A review of V15(Nurse) written statement dated 10/22/18 documents in part: "he(V15) heard V16 CNA say R12 was on the floor, upon entering R12's room, R12 was in a side lying position with arm's underneath her head. R12 was smiling. We asked V12 what happened, and he said he transferred R12 with mechanical lift into wheelchair and R12 was slouched position. Client R12 noted to be boosted in chair. He V12 came out looking for help and by that brief period of time, R12 was on the floor. When asked resident R12 simply stated "slid off the chair"

On 2/28/19 at 10:22am V14 (Physical Therapy Manager) said R12 was evaluated for physical and occupation therapy on 9/30/18 due to decrease in strength, decrease in transfer, reduced dynamic and static balance and increased need for assistance from others. V14 said R12 had poor truck control and was unable to shift her weight. V14 said R12 must be positioned well in her wheelchair she would not be able to stop herself from a fall, due to her weakness, but she must be positioned in chair sitting back, and with leg rest with feet supported by leg rest.

A review of R12's physical therapy evaluation dated 10/1/2018 documents sitting balance during ADL's poor (max (A), V14 said max A meants R12 required maximum assistance and upper extremity support to maintain balance and reach ipsilateral, unable to shift weight, kyphotic posture, head forward, R12 requires a great deal

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of assistance in all care including sitting at w/c (wheelchair per V14) level secondary to decrease BUE Bilateral upper exteremity strength, decrease strength in core, decrease sitting balance for feeding, of hard of hearing, and Left upper extrenity care decrease in confidence in herself.

On 2/28/19 at 1:40pm V11 (restorative nurse) said she does the training for staff on the use of the mechanical lift. V11 said there should be at minimum two people when transferrign a resident with mechanical lift. V11 said you need two people to allow for one to guide the sling with the resident in it and one person operate the machine. V11 said the risk for accident is high when using mechanical lift alone. V11 said a resident should never be left alone during a transfer, or left sitting half way in a wheelchair, it is unsafe. V11 said R12 has poor trunk control, R12 can slide out the chair and would not be able to brace herself due to weakness.

A review of facility policy titled "Resident Transfer" dated 1/13/2006 documents the facility will assess the resident to determine the safest method of physical transfer as a component of activities of daily living, if the resident has a sitting balance deficit a second care giver should be present to aid in balancing the resident while the second care giver applies the sling, the care giver should never reduce the level of device used unless directed by a nursing or therapy department, non-weight bearing residents must be designated as a total mechanical lift transfer.

A review of V12 transfer/lift competency worksheet dated 9/18/18 shows documents V12 signature with te date showing to check equipment before use, two people minimum,

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S9999	Continued From page 8 guest in middle of sling, at same color loops fully on hooks, be sure legs of mechnicl lift are fully apart and locked, support guest head as needed, and guide guest to surface, support their legs. (B)	S9999		