STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6012835	A. BUILDING: _____ B. WING _____	C 01/03/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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S 000	Initial Comments Facility Reported Incident of 12/14/2019 - IL118670	S 000		
S9999	Final Observations Facility Reported Incident of 12/14/2019 - IL118670 Statement of Licensure Violations: 300.1210b) 300.1210c) 300.1210d)6) 300.3240a) 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. c) Each direct care-giving staff shall review and be knowledgeable about his or her residents' respective resident care plan. d) Pursuant to subsection (a), general	S9999	Attachment A Statement of Licensure Violations	

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S9999	Continued From page 1	S9999		

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. (A, B) (Section 2-107 of the Act)

These Requirements are not met as evidenced by:

Based on interviews and record reviews, the facility failed to provide safety during incontinent care to R1 to prevent an avoidable fall. This applies to 1 out of 3 residents (R1) reviewed for falls in the sample.

This failure resulted in R1 rolling off the bed during incontinent care and sustaining a distal femur fracture requiring an overnight hospital stay, application of splint as well as increased pain.

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	IL6012835	A. BUILDING: _____ B. WING _____	C 01/03/2020

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S9999	Continued From page 2	S9999		

Findings include:

Incident report of 12/14/19 showed that R1 rolled off the bed and on to the floor while V3 (CNA-certified nurse's aid) was doing incontinent care. The incident report of 12/14/19 showed that R1 had diagnosis that contributed to the fall including: left sided weakness and stroke. The incident report of 12/14/19 also showed R1 with a diagnosis of below the knee amputation. It also showed that V3 stated he was changing R1's incontinent brief when he pulled the brief off of R1 and R1 rolled and fell on the floor. The incident report reflected that the immediate intervention to prevent similar incidents to occur was to have 2 CNAs assist with peri care.

On 1/2/20 at 10:45 AM, V3 (CNA) stated he was the CNA providing incontinent care to R1 on 12/14/19 when she fell from the bed. He had cared for R1 in the past and was familiar with her. R1 was alert. At that time he believed she was assessed as requiring the assistance of 1 for ADLs (activities of daily living) but required assistance of 2 for transfers because she was transferred with a mechanical lift. R1 was lying on her side with her right stump on the top and positioned in front of her full leg. He had one hand on her hip and the other hand was on the brief, and when he pulled the brief out from under her, she rolled off the bed. V3 stated, "she was close to the edge, but I thought she was fine where she was in the bed. It never happened before". He also said that she looked like she was in the center or just off center of the bed prior to him rolling her to the door. He immediately got the nurse who assessed R1 and R1 complained of hip pain. They made her as comfortable as they could on the floor until the ambulance arrived to take her to the hospital. He offered to go to the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6012835	A. BUILDING: _____ B. WING _____	C 01/03/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROSEWOOD CARE CENTER OF JOLIET	3401 HENNEPIN DRIVE JOLIET, IL 60435

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S9999	Continued From page 3	S9999		

hospital with her and she accepted. He stated that at other times, he has utilized a second person to assist with changing R1, but this time he did not attempt to get assistance, because it was late in the shift and he had already started providing care.

On 1/2/20 at 1:00 PM, V4 (RN) stated that she works with R1 regularly, and R1 is always very alert. V4 stated that she was notified by V3 that R1 had fallen from the bed while he was changing her. She went to the room and assessed R1 and because R1 was complaining of pain, they tried to keep her comfortable on the floor until the ambulance arrived. V4 stated that R1 was a large lady and when female staff would go in to change her, they utilized 2 or even 3 staff to change R1. However, V3 was a strong male and could change R1 himself, although she has seen him utilize a second person to change R1 at times. It would have been safer to utilize another staff to stand on the other side of the bed in order to prevent a fall. She requires 2 person assist for transfers and to pull her up in bed. Because she didn't have siderails, she had nothing to hold on to. Currently, when she is moved, since her injury, she complains of pain at about a level of a "7" (7 out of 10). When you touch her leg, she complains of pain out loud.

According to V3's progressive discipline form dated 12/15/19, V3 received discipline for the incident dated 12/14/19. V3's progressive discipline form dated 12/15/19 showed a summary that 2 CNAs should be utilized when providing peri care on a resident who has decreased bed mobility and has the potential to roll out of bed.

R1's MDS 3.0 (Minimum Data Set) showed that

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6012835	A. BUILDING: _____ B. WING _____	C 01/03/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROSEWOOD CARE CENTER OF JOLIET	3401 HENNEPIN DRIVE JOLIET, IL 60435

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S9999	Continued From page 4	S9999		

R1 is cognitively intact and R1's fall risk assessment dated 10/3/19 showed that R1 was at significant risk for falls because R1 has balance problems, weakness, fatigues quickly, has a below the knee amputation, history of stroke and paralyzed on left side.

R1's transfer code of 9/25/19 showed a recommendation of a valet bar on V1's bed. This was never done.

R1's occupational therapy evaluation and plan of treatment dated 9/25/19 showed V1's goal for safe bed mobility was to use siderails for proper positioning and showed V1 had risk factors that were due to R1's physical impairments, which put R1 at risk for fall.

On 1/2/20 at 10:00 AM, V1 (Administrator) stated that the facility only has a few electric beds and rents the rest when someone needs one, They do not use siderails anymore but if someone needs an assistive device to help them with repositioning, they can attach a valet bar to the beds, but only the beds they own, not the rented beds, as it entails drilling into the bed frame.

On 1/2/20 at 11:45 AM R1 said she fell out of her bed and broke her leg while V3 was "changing" her. R1 stated "I think he didn't pay attention." and stated she told V3 that she was falling out of the bed. She reported that while V3 was performing incontinent care V3 was also talking on his cell phone along with singing and dancing. R1 stated that since the fall she is in constant pain and in constant fear of falling. R1 stated that when R1 was first admitted to the facility V6 (RN) told R1 that R1 was going to have rails on R1's bed for safety but they were never applied. R1 stated that prior to falling R1 had told the nursing

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6012835	A. BUILDING: _____ B. WING _____	C 01/03/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROSEWOOD CARE CENTER OF JOLIET	3401 HENNEPIN DRIVE JOLIET, IL 60435

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S9999	Continued From page 5	S9999		

staff that R1 didn't want V3 to care for R1 because "V3 is not professional."

On 1/2/20 R4 said that V3 "acts younger than V3 is .... plays games while working," R4 stated that R4 has seen V3 singing, dancing, talking on V3's cell phone and playing with the facility's intercom system while on duty. R4 stated that she reported that information twice to both V1 and V2. R4 said that R1 told her that since R1's fall, R1 has been in a lot of pain, and having difficulty falling asleep at night.

On 1/2/20 R5 said that V3 is always "playing around, dancing, singing, on his cell phone and playing with the intercom system."

On 1/2/20 at 1:31PM V8 (CNA) said that R1 is very alert and oriented and that R1 has told V8 a few times before the fall that R1 didn't want V3 to care for R1 because "R1 doesn't trust V3 because V3 is not professional.". V8 stated that R1 is a two person assist and has always been a two person assist. V8 stated she has never performed incontinent care for R1 without two staff. V8 stated that she has seen V3 dancing and singing while on the floor. V8 stated that she prefers not to associate or work with V3 because of V3's lack of professionalism.

On 1/2/20 at 1:11PM V6 (RN) said that R1 is alert and oriented. V6 said that R1 is on pain medication related to the fall of 12/14/19 and has reported pain every day. V6 first said she did not remember talking to R1 about side rails on R1's bed but then said she did remember discussing with R1 about a "Valet" bar for R1's bed but could not recall when V6 talked to R1 about it or what exactly they talked about. V6 said that she has seen V3 singing, dancing, and talking on his cell

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROSEWOOD CARE CENTER OF JOLIET	3401 HENNEPIN DRIVE JOLIET, IL 60435

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S9999	Continued From page 6	S9999		

phone while on the floor while working. V6 said that R4 informed V6 a couple of weeks ago that R4 did like V3 because V3 "doesn't know what V3 is doing."

On 1/2/20 at 12:50 PM V7 (CNA) said that R1 is very alert and has told V7 that R1 is afraid of V3 and does not want V3 to care for R1. V7 said that prior to R1's fall R1 was "Coded" 3 person assist and now R1 is a 2 person assist. V7 said that V7 has never done incontinent care for R1 without the assistance of other staff. V7 said that V7 has seen V3 dancing and playing around and talking on V3's phone while working. V7 said that other residents have complained to V7 about V3 dancing, singing and talking on his phone while on the floor.

On 1/2/20 at 4:06 PM V9 (occupational therapy assistant) said that R1 has a recommendation for a bed valet and V9 highly recommend R1 be a 2 person assist during incontinent care since R1 does not have the bed valet. V9 also said that R1 had a communication card in R1's room showing R1 is a 2 person assist during incontinent care prior to the fall.

On 1/2/20 at 4:06PM V10 (physical therapist) said that V10 recommended R1 have a valet bar attached to R1's bed and highly recommended that R1 be a two person assist with incontinent care if R1 could not have the valet bar. V10 said that prior to R1's fall, R1 was already a two person assist and V10 said he saw R1's communication card in R1's room prior to the fall showing a two person assist.

On 1/2/20 at 3:46 PM V11(occupational therapist) said that V11 recommended R1 have a valet bar attached to R1's bed on 9/25/19. V11 said that

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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ROSEWOOD CARE CENTER OF JOLIET	3401 HENNEPIN DRIVE JOLIET, IL 60435

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S9999	Continued From page 7	S9999		

V11 informed the maintenance man that R1 needed a valet bar attached to R1's bed. V11 said this was the facility's procedure for occupational therapy recommendations for adaptive devices. V11 said that R1 could have used the valet bar with turning R1's self and possibly R1 could have prevented herself from falling out of the bed. V11 said that prior to R1's fall, R1 was a two person assist for bed mobility, ADL and incontinent care. V11 said that V11 highly recommends that R1 be a two person assist since R1 was unable to have valet bar attached to R1's bed. V11 stated that she saw R1's communication card on R1's door, prior to R1's fall and the communication card showed that R1 was a two person assist for incontinent care.

On 1/2/20 at 1:20 PM, V2 stated that prior to her fall, R1 was assessed as only needing one person's assistance for ADL's although she required 2 for transfers. This information was on her care card. V2 stated she could not provide a copy of her original care card typically kept in the residents room because it was a running document filled out in pencil and updated as the person's condition changed. It has since been changed to reflect the resident's change in condition. After R1's fall, they put new interventions in place, including a scoop mattress, 2 person assist for changing her incontinent brief, and a low bed with pads on the floor.. She stated she just learned today from R1's son that R1 had expressed concerns regarding V3's behavior and did not want him caring for her. V2 could not explain why this was confirmed by other staff and yet she hadn't heard of this. V2 denied hearing this information prior to that day.. V2 stated that she believed that staff stated that they went in to care for R1 with multiple staff because this had been recommended because of manipulative

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	IL6012835	A. BUILDING: _____ B. WING _____	C 01/03/2020

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S9999	Continued From page 8	S9999		

behavior on the part of R1, but those above-referenced staff stated they had multiple staff during R1's care because of her size and multiple medical conditions.

After speaking with R1, V2 stated that R1 had refused a valet bar on 1/2/20, and V2 had changed V3's assignment so that V3 would not be caring for R1.

On 1/2/20 at 2:35 PM, V5 (MD for R1) stated that the fall caused R1's fracture and that R1 is having pain due to her broken bone. She did not have surgery because they decided on conservative treatment, so she is in a splint. Without surgery, it will take 6 to 8 weeks for her broken leg to heal.

(B)