

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6010466	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 03/02/2017
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NAME OF PROVIDER OR SUPPLIER ROSEWOOD CARE CENTER OF GALESBURG	STREET ADDRESS, CITY, STATE, ZIP CODE 1250 WEST CARL SANDBURG DRIVE GALESBURG, IL 61401
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S 000	<p>Initial Comments</p> <p>Complaint Investigation</p> <p>1720969/IL91858 1720942/IL91833</p>	S 000		
S9999	<p>Final Observations</p> <p>Statement of Licensure Violations</p> <p>300.610a) 300.1210b) 300.1210d)3) 300.1210d)6) 300.3240a)</p> <p>Section 300.610 Resident Care Policies</p> <p>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.</p> <p>Section 300.1210 General Requirements for Nursing and Personal Care</p> <p>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</p>	S9999	<p>Attachment A Statement of Licensure Violations</p>	

Illinois Department of Public Health LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE 03/10/17
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S9999	<p>Continued From page 1</p> <p>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.</p> <p>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:</p> <p>3) Objective observations of changes in a resident's condition, including mental and emotional changes, as a means for analyzing and determining care required and the need for further medical evaluation and treatment shall be made by nursing staff and recorded in the resident's medical record.</p> <p>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.</p> <p>Section 300.3240 Abuse and Neglect</p> <p>a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. (Section 2-107 of the Act)</p> <p>These Requirements are not met as evidenced by:</p> <p>Based on interview and record review, the facility failed to implement interventions regarding immediate treatment for an acute grossly deformed left femur fracture for one of three residents (R1) reviewed for resident injury in the</p>	S9999		
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S9999	<p>Continued From page 2</p> <p>sample of three. This failure resulted in R1 being improperly turned and positioned by facility staff without any intervention for pain management or stabilization of an unsecured left femur fracture. R1 remained in the facility without emergent care for seven hours before being hospitalized. R1 was hospitalized with a spiral fracture of the left femur resulting in blood loss requiring a transfusion.</p> <p>Findings include:</p> <p>R1's medical record documents that R1 was admitted to the facility on 01/11/14 with the following diagnoses: Hypertension, Dementia, Malignant tumor of the thyroid. R1's most recent MDS (Minimum Data Set) dated 12/12/16 documents that R1 is rarely understood and is transferred using a mechanical lift with extensive assistance with bed mobility.</p> <p>Facility "Incident/Accident Report" dated 02/14/17 and signed by E4 (LPN/Licensed Practical Nurse) documents the following: "Called to room by CNA's (E5 and E6, Certified Nurse Aides) to check left thigh. Noted lower femur pushing up against the skin causing whitish discoloration with bluish discoloration around the perimeter. Internal rotation of foot noted. Left leg slightly shorter than the right. Also a 2 cm (centimeter) x 1 cm abrasion below left knee. Complaints of discomfort with range of motion."</p> <p>Nurses notes for R1 dated 02/14/17 document the following: "Called to room by CNA at 4:00 AM. Noted left lower femur pushing up, against the skin causing a whitish discoloration with bluish discoloration around perimeter. Internal rotation of foot noted. Left leg slightly shorter than the right. Also a 2 cm x 1 cm abrasion below left</p>	S9999		

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S9999	<p>Continued From page 3</p> <p>knee. Complains of discomfort with range of motion."</p> <p>On 2/22/17 at 11:56 AM, E5 (CNA) stated that on 2/14/17 at 4:00 AM, "It (R1's left leg) looked like her bone was going to pop out of her skin...(R1) was incontinent and (E6, CNA) and me were going to clean her up. That's when we rolled her and she made a noise and grimaced. And that's when we (E5 and E6, CNA's) saw it (R1's leg deformity). So (E6) went and got (E4, LPN). (E4) checked (R1) out. I don't think (E4) called anyone right away. (E4) made us (E5, E6 and E8, CNA's) clean her up around 6:00 AM. We had (E3, ADON/Assistant Director of Nursing) stand in while we cleaned her. That bone looked like it was going to pop out of her skin. I almost fainted when I saw it. We (E5, E6 and E8, CNA's) wanted someone in there because we had to roll her and we were scared. (R1) grimaced and yelled when we moved her. She cried out. I never heard anyone mention calling 911. I think someone should have because (R1's) leg looked so bad."</p> <p>On 2/22/17 at 3:37 PM, E6 (CNA) stated, "(E5, CNA) came down to ask me to help clean (R1) up for a shower around 4:00 AM. (R1) was incontinent of stool. I went to roll (R1) over and that's when she made a noise - and when I rolled her back over that's when we saw the bone sticking out. It was her left femur. It looked like it was protruding through her skin. We (E5, E6 and E8, CNA's) were told to clean (R1) up so we had (E3, ADON) come down around 6:00 AM and watch while we cleaned (R1) up because we were afraid to move her. We thought that her bone was going to pop through her skin if we moved her too much. (E4, LPN) put it (addressing R1's leg deformity) off after (E4) was</p>	S9999		
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S9999	<p>Continued From page 4</p> <p>made aware of (R1's) deformity. (E4) continued caring for the other residents. I think someone should have called 911. I asked (E4) about (R1's) leg after (E4) looked at it, and (E4) said to me that she felt like it was arthritis and she would call the doctor later."</p> <p>On 2/22/17 at 11:48 AM, E8 (CNA) stated that on 2/14/17, "I think (E5 and E6) found it (R1's left leg deformity) between 2:00 AM - 3:30 AM. I (E8) was told that they (E5 and E6) went in to get (R1) ready for a bed bath, they rolled her over and they rolled her back because she yelled. I helped them clean (R1) up between 6:00 AM and 6:30 AM. (R1) was incontinent of feces. (E4, LPN) and (E9, RN/Registered Nurse) told us (E5, E6 and E8) to clean (R1). We had to roll her. Honestly, we didn't want to move her at all because we were scared to. I was scared that the bone was going to pop through. You could see the bone moving around even if we barely moved her. (R1's) leg was never splinted that I saw. We just held her leg when we moved her. (E3, ADON) was just in the room for direction. She did not assist in cleaning (R1) up. It looked like (R1) was in pain because she grimaced when we moved her."</p> <p>On 02/22/17 at 1:07 PM, E4 (LPN) stated, "The aides (E5 and E6, CNA's) came and got me from (another room). They said we need you down in (R1's) room. They pulled back her covers and there was the bone sticking up against her skin. Bruising and white skin tinting from the bone pushing up against the skin wall with a small superficial abrasion on her left lateral knee. Her leg was obviously broken. It was internally rotated. I don't know how she got the abrasion on her left knee. I did a body assessment and there were no other findings other than her leg. I asked</p>	S9999		

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S9999	<p>Continued From page 5</p> <p>the girls what happened and they couldn't give me an answer. They didn't know. They said they didn't notice anything on a previous bed check. R1 had feces between her toes. (R1) can't turn herself in bed. It was wrong but I continued trying to care for other residents. I told the aides to leave her still for the time being. I called the doctor around 7:10 AM once I caught up with cares. Sometimes he can be a difficult doctor to deal with." E4 then stated that E4 did not administer any of R1's morning medications or any pain medication to R1.</p> <p>Facility interview conducted and signed by E7 (Corporate) dated 02/15/17 documents the following: "(R1) only hollered out when she was turned or the leg was moved...(E4) stated she went to the nurses station to sit down and think about the situation as to what had occurred, why they didn't see the leg earlier. I asked (E4) what she did from the time she found the injury to the time she called the physician and she stated 'I did dressing changes on (other residents).' She also responded 'I took care of all the other residents answering call lights, etc.' I asked (E4) why she waited three hours to call the physician and three and a half hours to call the son and she replied, 'It was just so crazy that night, I can't really answer that question.'"</p> <p>On 2/22/17 at 9:06 AM, E3 (ADON) stated that E4 (LPN) approached E3 on 2/14/17 between 5:00 AM - 5:30 AM requesting that E3 take a look at R1's left leg. E3 stated, "I saw an obvious deformity. (R1's) femur bone was pushing against the skin slightly to the left of the knee cap. It seemed to be internally rotated to the right. I did not check for a pedal pulse. I went out and instructed (E5, E6 and E8, CNA's) to clean (R1)</p>	S9999		
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S9999	<p>Continued From page 6</p> <p>up. I told (E4, LPN) that she needed to contact the doctor and then went into my office to do my duties...(R1's) leg was never splinted. I didn't direct anyone to splint her."</p> <p>On 2/27/17 at 9:24 AM, E10 (CNA) stated that E3 (ADON) came and got E10 from the other end of the building on 2/14/17. E10 stated, "I usually work on 200/300 hall and we have a resident down there that broke her femur about 2 months ago. So (E3) asked me to help roll (R1) since I'm familiar with rolling someone that has a fractured femur. So I went into (R1's) room, but I didn't help. Once I saw (R1's) leg, I said 'that's way worse than what I'm used to'...(R1's) leg looked awful."</p> <p>Nurses notes for R1 dated 02/14/17 documents that R1's physician (Z1) was not notified until 7:20 AM of R1's injury when an on-site x-ray was ordered. The same nurses noted document mobile x-ray unit arrived and did x-ray at 9:00 AM.</p> <p>Nurses notes for R1 dated 02/14/17 at 10:00 AM document the following: "Sons stated they want (R1) sent to the emergency room. Informed getting Dr. (doctor) order to send and getting x-ray results to (Z1). 10:45 AM Left per (local ambulance service)."</p> <p>On 02/23/17 at 11:37 AM, Z1 stated, "I would expect to be notified of a change of condition immediately. They did not notify me until after 7:00 AM on 2/14/17 and I don't know why. I would have expected to have been notified of this type of injury immediately. When I was called, the staff was not descriptive of the extent of (R1's) injuries. If I knew how bad it was, I would have just sent her in."</p>	S9999		
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S9999	Continued From page 7 On 2/22/17 at 1:48 PM, Z5 (local ambulance Emergency Medical Technician) stated that Z5 arrived to the facility on 2/14/17 around 10:30 AM to transport R1 to the hospital. Z5 stated that Z5 found R1 lying in bed with a grossly deformed left leg. Z5 then stated, "No one could explain what happened. Her left leg was obviously broken. It was just loose from the area fractured down to her foot. They (facility) did not have her leg splinted. I can't believe that she'd been lying there since 4:00 AM with a fracture of that degree. I applied a splint to her left leg. She grimaced when we moved her. She was nonverbal, but you could tell by the look on her face that she was very uncomfortable." On 2/21/17 at 4:51 PM, Z4 (local hospital Emergency Room Physician) stated that R1 arrived to the emergency room on 2/14/17 with an obvious deformity to (R1's) left femur. Z4 stated, "She had a spiral fracture of her left femur...the bone was going to protrude through her skin if we would have left it the way that it was...I would have expected a doctor to be notified immediately with an obvious fracture of that nature and I would have expected her to be sent in right away." Z2's (R1's Orthopedic Physician) Consultation for R1 dated 2/14/17 documents the following: "(R1) was apparently found to have a fracture of her left femur in the supracondylar area above total knee prosthesis. (R1) is severely demented and at best would get up in a chair with a (mechanical) lift. On examination, (R1) has moderate swelling and moderate deformity of the distal femur. I personally evaluated her x-ray. She has a spiral supracondylar fracture of her left femur." On 2/27/17 at 10:25 AM, Z2 (R1's Orthopedic	S9999			

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S9999	<p>Continued From page 8</p> <p>Physician) stated that R1 arrived to the emergency room with an obvious deformity of the left femur. Z2 stated, "She had a spiral fracture of her left femur...that fracture didn't happen by itself. It was caused by some type of trauma, possibly a twisting injury or a fall...she shouldn't have been moved or rolled unless her leg was splinted. I wouldn't want her leg flopping all over the place...(R1) had a large amount of bruising to her left knee. It was a complication of a large amount of bleeding from her fracture. Moving her leg around could have caused her to bleed more. If she would have been splinted or sent in sooner, it would have made a difference in her amount of blood loss."</p> <p>On 2/21/17 at 10:53 AM, Z3 (R1's Hospitalist) stated that R1 was acutely anemic the next morning after R1 was admitted to the hospital, and R1 received a blood transfusion with little to no improvement and was then placed on comfort measures.</p> <p>On 2/21/17 at 9:15 AM, Z7 (R1's family member) stated that it was determined after R1 was hospitalized on 2/14/17 that there was nothing more they could do for R1. Z7 then stated the decision was made to make R1 comfort measures, and R1 expired on 2/20/17.</p> <p>(A)</p>	S9999		
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