STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6008098	A. BUILDING: _____ B. WING _____	C 04/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROCHELLE GARDENS CARE CENTER	1021 CARON ROAD ROCHELLE, IL 61068

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S 000	Initial Comments Investigation of Facility Reported Incident of April 18, 2024/IL172378	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.1010h) 300.1210b)5) 300.1210d)3)6) 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 300.1010 Medical Care Policies h) The facility shall notify the resident's physician of any accident, injury, or significant change in a resident's condition that threatens the health, safety or welfare of a resident, including, but not limited to, the presence of incipient or manifest decubitus ulcers or a weight loss or gain of five percent or more within a period of 30 days. The facility shall obtain and record the physician's plan of care for the care or treatment of such accident, injury or change in condition at the time of	S9999		

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notification.

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.

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:

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.

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.

This REQUIREMENT is not met as evidenced by:

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Based on interview and record review the facility failed to thoroughly assess a resident (R1) following an injury of unknown origin. This failure resulted in a delay in identifying and obtaining medical treatment for a clavicle fracture. This applies to 1 of 3 residents (R1) reviewed for resident injury in the sample of 4.

The findings include:

R1's face sheet shows she has diagnoses including Pick's Disease, Mental Disorder, Schizoaffective Disorder Bipolar Type, Mild Intellectual Disability, Anxiety Disorder, and Displaced Fracture of the Shaft of Right Clavicle.

R1's active Care Plan shows the following: She has impaired cognition and altered mood and thought process with behavioral changes. R1 has a self-care deficit and requires staff assistance with her activities of daily living (ADL's) including toileting, transferring, and bathing. On 4/19/24 R1's care plan was updated to show R1 has a right mid clavicle fracture and requires her to wear a sling to her right arm and use a wheelchair for mobility.

On 4/30/24 at 7:55 AM, R1 was sitting in a wheelchair in the dining area of the facility. She had her right arm in a sling. R1 told this surveyor she fell into the bathtub in her room and broke her arm. R1 said the injury was painful and her arm hurts.

R1's shower sheet dated 4/12/24 completed by V7 (Certified Nursing Assistant/CNA) shows findings of bruising on her right shoulder. The body diagram on the form shows scribbled lines

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on the right chest above the clavicle to reflect the area where R1's bruising was. The shower sheet dated 4/12/24 was cosigned by V6 (Registered Nurse/RN).

There is no documentation in R1's Electronic Medical Record (EMR) in the nursing progress notes or any assessment of a bruise or injury to R1's shoulder until 4/18/24.

A nursing note completed on 4/18/24 by V6 shows R1 came to her and informed her that her shoulder hurt. When V6 examined R1's shoulder there was swelling, and yellowish bruising noted. The note shows R1 reported having a fall in her bathroom, over a week ago, getting herself up from her toilet and fell forward into her bathtub. R1's physician was contacted and an order for an X-ray was obtained.

An X-ray report dated 4/18/24 shows R1 has a superior angulated comminuted oblique fracture of the mid right clavicle.

R1's progress notes show R1 went out to an orthopedic follow up appointment on 4/19/24 and the Orthopedic follow up note for R1 shows R1 should wear a sling daily until follow up and cannot use her walker.

On 4/30/24 at 8:15 AM, V5 (RN) said she was unable to recall the exact date, but she did notice a yellowish bruise on R1's right chest/shoulder area. She believes it was about a week prior to when it was discovered that R1 had a fractured clavicle (which was on 4/18/24). She said she at the time she saw the bruising she asked R1 what happened and R1 responded she fell in her bathroom; she asked her if it hurt and R1 said no. V5 denied seeing any bump or lump to R1's chest

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area. On 4/30/24 at 9:50 AM, she said when she looked at R1's bruising she didn't do a full assessment and she should have investigated it further. V5 said she is at the facility all the time and works a lot of shifts. On 4/30/24 at 1:50 PM, V5 clarified for this surveyor that she did not go back and assess R1's bruising any further because she knew it was there, and she did not document the injury in R1's EMR.

Facility provided staffing schedules show V5 worked at the facility on the following dates: 4/12/24, 4/14/24, 4/15/24, 4/16/24, 4/17/24 and 4/18/24.

On 4/30/24 at 9:40 AM, V6 (RN) said she was not aware that R1 had a bruise or an injury until 4/18/24 when it was reported to her. She then went to assess R1's shoulder and found a large yellowish fading bruise with a lump to the right chest/ clavicle region. R1 told V6 she had a fall a week ago in her room. V6 then called V3 (R1's Primary Care Physician) and obtained orders for an X-ray which showed R1 had a fractured clavicle.

On 4/30/24 at 1:35 PM, this surveyor showed V6 R1's shower sheet dated 4/12/24 which was completed by V7 (CNA) that was signed off by her showing a large yellow bruise to R1's shoulder and written on the shower sheet was "bruise on RT shoulder". V6 verified it was her signature on the sheet but said she did not go and assess the bruising to R1's shoulder. V6 said sometimes they just sign off on the shower sheets and she did not notice it said about R1 having a bruise. V6 said "It's my fault I should have looked into it that day because the bump was probably worse, and I could have called for an X-ray sooner." V6 did not document anything

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in R1's EMR prior to 4/18/24 about the bruising/injury.

On 4/30/24 at 1:30 PM, V7 (CNA) said she gave R1 a shower on 4/12/24 and noticed a large yellowish bruise on her right shoulder. V7 said she also could feel a slight lump on R1's shoulder. V7 said she cannot recall what nurse she told, but she did tell them about the bruise and lump, and they told her it was an old bruise from a fall.

On 4/30/24 at 10:30 AM, V4 (Nurse Practitioner) said many factors can come into play but typically bruises start out as purple in color and then fade to yellow, and a yellowish bruise would be consistent with an injury 5-9 days old. V4 said at minimal staff should notify the residents physician, do a complete assessment, check for pain, and check for range of motion. V4 said a clavicle fracture is very painful and the primary treatment is to immobilize the arm. V4 said a clavicle fracture could be the result of a fall especially if the resident reports having a fall.

On 4/30/24 at 12:05 PM, V3 (R1's Primary Care Physician) said he was not notified of any injury or fall for R1 until 4/18/24 when the facility nurse called him about bruising and swelling to R1's right shoulder. He said he ordered an X-ray that day and would have ordered one sooner had they called him about the bruising/injury before 4/18/24. V3 said the type of clavicle fracture R1 has is consistent with a fall on your side. He said a fading yellow bruise is also consistent with an injury a week ago and he describes it as a "resolving bruise." V3 said an angulated (displaced) clavicle fracture is generally a painful fracture and the key is immobilization of the arm to decrease pain. V3 said the mechanism of the

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fracture would likely be from a fall and them not notifying him sooner is an issue.

On 4/30/24 at 12:40 PM, V2 (Director of Nursing/DON) said a resident injury should be documented in the EMR in the nursing progress notes or assessments. V2 said when a resident injury is identified the nurses should do a head-to-toe assessment, assess for pain, and inform the doctor to obtain treatment orders.

On 4/30/24 at 12:48 PM, V1 (Administrator) said she was shown the bruise and saw lump on R1's shoulder on 4/18/24. She thought something did not seem right, so she asked the nurse to call the physician for an X-ray order and when that came back it was identified that R1 had a fractured clavicle. V1 said when she investigated the incident R1 told her she had a fall in her bathroom, and she got herself up.

The facility provided Abuse Prevention Policy revised 11/28/16 states, "The nursing staff is additionally responsible for reporting on a facility incident report the appearance of bruises, lacerations, other abnormalities, or injuries of unknown origin as they occur. Upon report of such occurrences, the nursing supervisor is responsible for assessing the resident, reviewing the documentation and reporting to the administrator or designee."

"B"