STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145821	A. BUILDING _____ B. WING _____	C 11/15/2004

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROSEWOOD CARE CENTER OF ELGIN	**2355 ROYAL BOULEVARD ELGIN, IL 60123**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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
F9999	FINAL OBSERVATIONS	F9999		

Incident ot 10-13-2004

LICENSURE FINDINGS:

300.3100 d)2) All exterior doors shall be equipped with a signal that will alert the staff if a resident leaves the building. Any exterior door that is supervised during certain periods may have a disconnect device for part-time use. If there is constant 24 hour a day supervision of the door, a signal is not required.

Based on record review and staff interview the facility failed to supervise residents on 10/13/04 when an exit door alarm was turned off.

The findings include:

R1 was a 93 year old resident who was admitted on March 5, 2004. Among R1's diagnosis on the physicians order sheet 10/1/04 are dementia, anxiety and depression.

R1's physician order sheet of 10/1/04 under general orders states may leave the facility on pass with supervision.

E1, activity aide, was interviewed on 10/21/04 at 3:22pm per phone. E1 stated "R1 left the exercise group around 10:40am. She does that, She'll leave and come back."

E2, maintenance man, was interviewed on 10/21/04 at 3:35pm by phone. E2 provided the following information: "I was working on the

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F9999	Continued From page 4	F9999		

heater in room 118. I drained the waterline into a bucket, turned off the door alarm about 10:45am, threw the water out the door. I went back to room 118, collected my tools and went to the nurses' station to turn the door alarm back on. It probably took five minutes."

E3, registered nurse, was interviewed per telephone on 11/05/04 at 1:10pm. E3 provided the following information: "On 10/13/04 at 10:55 am R1 was brought into the facility's front entrance by a visitor who found R1 sitting by the door at the end of the building. R1 told the visitor, "my wheel chair is stuck on the grass". R 1's vitals were checked. R1 was in no distress. Skin was warm and dry, wearing proper clothing, blouse, pants, socks, shoes, and sweater. R1 said, I went to go shopping.

E4, administrator was interviewed on October 19, 2003 at 3:00pm in the administrator's office. The administrator provided that following information: "As soon as R1 was returned inside it was discovered the door alarm to exit door one had been turned off at 10:45am and turned back on at 10:55am by the maintenance man. A head count was done immediately. All guests were accounted for. The maintenance man was counseled in writing. Staff were inserviced about never unalarming a door without notifying the nurse on the hall. If the unalarmed door is unsupervised it must immediately be realarmed. We are having weekly door alarm drills checking to see if alarms are on. R1 was not considered an elopement risk. R1 had never done this before. R1 was monitored every 15 minutes for 72 hours. She hasn't made any attempts to go out.

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F9999	Continued From page 5 On October 19, 2004 at 3:39pm door alarms were tested. All alarms were on and working with staff responded to test.	F9999		