	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUII		PLE CONSTRUCTION G	(X3) DATE SU COMPLE	JRVEY TED
		145563					C 1/2005
	ROVIDER OR SUPPLIER A ST ANNE CENTER			44	EET ADDRESS, CITY, STATE, ZIP CODE 405 HIGHCREST ROAD OCKFORD, IL 61107	1 03/3	172003
(X4) ID PREFIX TAG	(EACH DEFICIENCY	SUMMARY STATEMENT OF DEFICIENCIES ACH DEFICIENCY MUST BE PRECEEDED BY FULL EGULATORY OR LSC IDENTIFYING INFORMATION) BY THE PROVIDER'S PLAN OF CORRECTION OF CORRECTION SHOULD BE CONTROL TO THE APPROPRIATE DEFICE TO THE APPRO		BE CROSS-	(X5) COMPLETION DATE		
F9999		E FINDINGS: Medical Care Policies	F99	999			
	of any accident, injuresident's condition safety or welfare of	notify the resident's physician ary, or significant change in a that threatens the health, a resident, including, but not ence of incipient or manifest					

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI		PLE CONSTRUCTION G	(X3) DATE SU COMPLE	
		145563	B. WIN				C 1 /2005
	PROVIDER OR SUPPLIER			4	EET ADDRESS, CITY, STATE, ZIP CODE 405 HIGHCREST ROAD COCKFORD, IL 61107	00,0	.,,2000
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOULD REFERENCED TO THE APPROPRIATE D	BE CROSS-	(X5) COMPLETION DATE
F9999	percent or more with facility shall obtain a plan of care for the accident, injury or confortification. Section 300.1210 Conformation and Personal The facility must and services to attain practicable physical well-being of the releast resident's complan of care. Adequation of care and personal care needs by General nursing minimum the follows a 24-hour, seven do a 3) Objective obtaining and determining cand determining cand determining cand determining cand determining cand determining the section 300.1220 Services by The DON shall some sident of the pool of the	a weight loss or gain of five thin a period of 30 days. The and record the physician's care or treatment of such thange in condition at the time. Seneral Requirements for nal Care provide the necessary care ain or maintain the highest I, mental, and psychological sident, in accordance with aprehensive assessment and late and properly supervised ersonal care shall be provided meet the total nursing and sof the resident. care shall include at a ing and shall be practiced on ay a week basis: servations of changes in a , including mental and , as a means for analyzing re required and the need for luation and treatment shall be aff and recorded in the	F99	999			

-	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI		IPLE CONSTRUCTION IG	RECTION JLD BE CROSS-	
		145563	B. WIN				C 1/2005
	ROVIDER OR SUPPLIER A ST ANNE CENTER			4	REET ADDRESS, CITY, STATE, ZIP CODE 405 HIGHCREST ROAD ROCKFORD, IL 61107		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOULD REFERENCED TO THE APPROPRIATE I	BE CROSS-	(X5) COMPLETION DATE
F9999	Personnel, represe nursing, activities, or modalities as are or be involved in the pplan. The plan shall reviewed and modifineeded as indicated. The plan shall be remonths. These REGULATIO by: Based on interview failed to: 1. Ensure that a resincision has a clear surgical site daily a 2. Document in the when a dressing to soiled or re-applied 3. Notify the orthop resident's frequent contamination of th 4. Notify the orthop possible signs and for a resident with or hip wound. 5. Provide immedia	al care and nursing needs. Inting other services such as dietary, and such other redered by the physician, shall reparation of the resident care be in writing and shall be fied in keeping with the care do by the resident's condition. Eviewed at least every three on the property of the	F99	999			
		of Hypertension, Chronic etes Mellitus, Fracture Neck					

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI		IPLE CONSTRUCTION	(X3) DATE SU COMPLE	JRVEY TED
		145563	B. WIN				C 1/2005
	PROVIDER OR SUPPLIER			4	REET ADDRESS, CITY, STATE, ZIP CODE 1405 HIGHCREST ROAD ROCKFORD, IL 61107		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOULD REFERENCED TO THE APPROPRIATE I	BE CROSS-	(X5) COMPLETION DATE
F9999	facility's face sheet sheet also documer information, that R1 resuscitation). The documents that R1 staff for all of her acadmitted to the faci right hip repair and Hospital Discharge R1's Nurse's Notes show that R1 was h1 had approximated during this time. On that there is "constate Treatment Admicontained no evided dressing was applied keep it clean on a refailed to show any sinterventions concentris physician's order admission on 11/17. There was no evident hip dressing for R1 that the orthopedic the right hip repair a notified concerning possible contaminar R1's surgical consustates, "I saw the part which time the presentation of the	teral Blindness per the dated 11/17/04. The face onts, under additional was a full code (full Minimum Data Set of 12/6/04 was totally dependent on ctivities of daily living. R1 was lity on 11/17/04 after having a rod placement per the Sheet dated 11/17/04 from 11/18/04 to 12/7/04 avaing frequent loose stools. R y 14 uncontrolled loose stools in 11/19/04 Nurse's Notes state ant stool (seeping)". Review of inistration Records for R1 nee that a surgical site and to the right hip incision to outine basis. R1's care plan specific care approaches/string R1's right hip wound. R ars were reviewed from 1/04 to discharge 12/7/04. There was also no evidence surgeon, who had performed and rod placement, was ever R1's frequent diarrhea for	F99	999			

-				DATE SURVEY COMPLETED			
		145563	B. WIN	IG			D 1 /2005
PROVENA ST ANNE CENTER (X4) ID SUMMARY STATEMENT OF DEFICIENCIES				44	EET ADDRESS, CITY, STATE, ZIP CODE 405 HIGHCREST ROAD OCKFORD, IL 61107		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOULD REFERENCED TO THE APPROPRIATE D	BE CROSS-	(X5) COMPLETION DATE
F9999	well as the gentlem the patient's transposignificant problems the past few days. I probably has a wou superficial wound. Which I believe is set stool when she still Irrigation, debridem will have to have the cannot guarantee the mentioned infection inside rather than froutside. When she not have a dressing. During phone intervapproximately 10:15 Surgeon), verified het the surgical consult further stated, "I was facility was unable site clean. I should been made aware cordered some type help protect the wo should have had a as needed." R1's Hospitalist His 7/04 states, "For the been having a signification increased volume of generalized poor not seen by Z2 yesterd her wound in her rigapart or open) and	an who was there who was ort, the patient has had some is with severe diarrhea over impression: I think she and infection of the right hip. The most proximal wound econdary to being soiled by had her staples in. Plan: I dent today. I do not think she is e hardware out although I hat because I feel this is as I a from the outside towards the saw me on Monday, she did gover that right hip." I view conducted on 3/23/05 at 5 a.m. Z2 (Orthopedic his findings documented on eant's record dated 12/9/04. Z2 is never notified that the to keep the surgical wound have been notified. If I had of the problem I would have of impermeable dressing to und from contamination. R1 clean dressing applied daily or an east 2-3 days she (R1) has afficant amount of lethargy and of her chronic diarrhea and ursing home care. She was any when he had noted that ght hip had dehisced (split the staff at the facility was not site clean and there was a	F99	999			

AND PLAN OF CORRECTION	DENTIFICATION NUMBER:	` '	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
	145563	B WING			C 1 /2005	
PROVENA ST ANNE CENTER SUMMARY STATEMENT OF DEFICIENCIES			44	REET ADDRESS, CITY, STATE, ZIP CODE 405 HIGHCREST ROAD COCKFORD, IL 61107		
PREFIX (EACH DEFICIENCY MUST	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		Х	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOULD B REFERENCED TO THE APPROPRIATE D	BE CROSS-	(X5) COMPLETION DATE
to deteriorate and the paramedics to go for her noticed that her blood prand brought her to the eshe was noted to be sepinfected right hip wound. Microbiology Report date that R1's right hip wound showed that there was a Escherichia Coli present site. During a phone interview at approximately 3:00 p. Physician) verified his fir the Hospitalist History ar 12/7/04. Z1 further state to it that R1 was brought facility nursing staff. Nurse's Notes dated 12/document that R1 had a Blood Pressure (BP) of and respirations of 16. R lungs clear. 3:05 p.m. cafor a return call. 3:30 p.m. physician's office called physician's nurse at 3:40 condition. Waiting for a return for the separation of the separation.	col around her area as ent's condition continued atient was brought by r dialysis when they ressure was awfully low mergency room where offic and had a severely site." ed 12/8/04 documents d was cultured and a moderate growth of t in the surgical wound of conducted on 3/23/05 m., Z1 (Hospitalist and and a conducted on a decent of the first to the hospital not the conducted on	F99	999			

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI		PLE CONSTRUCTION G	(X3) DATE SU COMPLE	
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F9999	regularly scheduled became unrespons rate of 34, BP was %. R1 was transporroom for treatment the hospital emerge and 40 minutes afte being severely hypomore and 40 minutes after being severely hypomore and 40 minutes after being severely hypomore and 40 minutes after being severely hypomore and interview approximately 2:00 stated, "I do not reconcerning R1's located, "I do not reconcerning R1's located at the time. R1 was was aware that she asked by the survey blood pressure, and During an interview approximately 3:00 consider a blood pressure, and During an interview approximately 2:30 stated, "E4 should be a blood pressure the Procedure states the there is a facility me not have waited for physician."	vas transporting R1 to a I dialysis treatment. R1 ive and had a weak pulse at a 90/60, pulse oximetry was 78 rted to the nearest emergency and evaluation. R1 arrived at ency room at 4:40 p.m. 1 hour er she was assessed by E4 as otensive. conducted on 3/22/05 at p.m. E4 (Registered Nurse) call Z2 being notified ose stools." When asked by the did not call for an ince when she first obtained a fied, "R1 was not symptomatic into dizzy or light headed. I was a full code." E4 was yor if R1 consistently ran a low	F99	999			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MI A. BUIL		PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		145563	B. WIN				C 1 /2005
	AME OF PROVIDER OR SUPPLIER PROVENA ST ANNE CENTER STREET ADDRESS, CITY, STATE, ZIP CODE 4405 HIGHCREST ROAD ROCKFORD, IL 61107 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION						
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEEDED BY FULL		ID PREFIX TAG	K	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOULD B REFERENCED TO THE APPROPRIATE D	BE CROSS-	(X5) COMPLETION DATE
F9999	Death for R1 docur	nents that R1 expired due to be of Septic shock related to	F99	99			