STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145908	A. BUILDING _____ B. WING _____	C 06/08/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AMBERWOOD NURSING & REHAB CENTER	**2313 NORTH ROCKTON AVENUE ROCKFORD, IL 61103**

(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
F 514	Continued From page 33 couldn ' t be sure, as the documentation was not clear.	F 514		
F9999	FINAL OBSERVATIONS LICENSURE VIOLATIONS 300.1010h) 300.1210a) 300.1210b)2) 300.1210b)3) 300.3240a) 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 notification. Section 300.1210 GENERAL REQUIREMENTS FOR NURSING AND PERSONAL CARE a) The facility must 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 assessment and plan of care. 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. Restorative measures shall include at a minimum the	F9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145908	A. BUILDING _____ B. WING _____	C 06/08/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AMBERWOOD NURSING & REHAB CENTER	**2313 NORTH ROCKTON AVENUE ROCKFORD, IL 61103**

(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	Continued From page 34 following procedures b)2) All treatments and procedures shall be administered as ordered by the physician. b)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. Section 3240 ABUSE AND NEGLECT a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. Based on interview and record review the facility failed to assess and monitor a resident who had a reddened groin area since admission. Nursing staff failed to consistently administer Mycostatin powder as ordered by the physician. Nursing staff failed to consistently document a resident's skin condition and failed to report changes to the physician in a timely manner. These failures resulted in R1 requiring emergency hospitalization on 1/17/06 with a diagnosis of Cellulitis with likely sepsis. The findings include: R1 has diagnoses of Leg Varicosity with Ulcer, Umbilical Hernia Repair, Diabetes Mellitus, Spinal Stenosis of Lumbar Spine, Rheumatoid Arthritis, and Hypertension, per Physician's Order Sheet for January, 2006. The assessment dated 1/03/06 documented that R1 had no short or long term memory deficits and was independent in her decision making. The assessment further	F9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145908	A. BUILDING _____ B. WING _____	C 06/08/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AMBERWOOD NURSING & REHAB CENTER	**2313 NORTH ROCKTON AVENUE ROCKFORD, IL 61103**

(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	Continued From page 35	F9999		

documented that R1 was highly involved in her activities of daily living but did require one staff to physically assist her. Nurse's Notes dated 12/30/05 show that R1 was admitted to the facility at 3:30 PM. The Nurse's Notes also document that R 1 has 3+ bilateral lower extremity edema with redness.

R1's Hospital Nursing Transfer Information Form dated 12/30/05 verified that R1 had bilateral lower extremity edema with redness. The Transfer Information Form also said that facility staff at the nursing home were to "keep abdominal and groin folds clean and dry and apply Mycostatin powder PRN (as needed)."

The facility's Nursing Admission Form dated 1/2/06 documents that R1's groin is moist and reddened. The Admission Form also shows that R1 requires assistance with grooming and hygiene.

Review of R1's clinical record beginning 12/30/06 to 1/17/06 showed that R1's skin status was not consistently documented or followed up on by nursing staff. There is no evidence that during this time a Registered Professional Nurse ever assessed R1's skin condition. R1's Treatment Administration Record for January 2006 documents that nursing staff applied Mycostatin powder to R1's abdominal folds and groin area on 1/12/06 and 1/13/06 only. At no time was the Mycostatin powder applied prior to 1/12/06. The Treatment Administration Record further documents (under the weekly summary) that R1 had excoriation to abdominal folds. R1 went 13 days without assessment or treatment to her abdominal folds and groin.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145908	A. BUILDING _____ B. WING _____	C 06/08/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AMBERWOOD NURSING & REHAB CENTER	**2313 NORTH ROCKTON AVENUE ROCKFORD, IL 61103**

(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	Continued From page 36	F9999		

Nurse's Notes dated 1/14/06 document that at 4: 00 PM R1 had a rash. The Keflex R1 was receiving was held and a call was placed to R1's physician. There is no evidence in R1's clinical record that facility staff spoke to Z1(physician) or received any orders concerning R1's rash on 1/ 14/06.

R1's Daily Skilled Nursing Assessment Forms beginning 1/5/06, lack any documentation concerning her abdomen or groin folds. On 1/14/ 06 it is documented that R1 has a fungal odor to her groin area. There is no evidence that this finding was reported to R1's physician.

The Nurse's Notes lack any documentation concerning R1's abdominal folds and groin until 1 /15/06. On 1/15/06 at 1:00 AM, Nurse's Notes show that the physician was called related to R1 's abdominal and groin folds being red and irritated. Nurse's Notes further document that there was mild bleeding, skin peeling, and serous drainage present. There was also purulent drainage around the navel area. Z1 gave nursing orders to stop the Keflex and Nystatin powder and give Benadryl mg caps every 6 hours. Staff were to cleanse the irritated areas with mild soap and water and apply Polysporin ointment to the navel area and apply Lotrisone Cream twice daily to the abdominal folds and groin. This was the first time that Z1 was made aware of R1's rash/ irritation to her abdomen and groin area since admission.

The Nurses Notes dated 1/16/06 at 1:50 AM state, "Z1 called due to incontinence causing burning to irritated skin underneath abdominal

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145908	A. BUILDING _____ B. WING _____	C 06/08/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AMBERWOOD NURSING & REHAB CENTER	**2313 NORTH ROCKTON AVENUE ROCKFORD, IL 61103**

(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	Continued From page 37	F9999		

folds and groin area. Z1 gave a nursing order for an indwelling urinary catheter." There is no documentation showing that Z1 was updated on R1's skin condition. On 1/16/06 at 2:00 PM, approximately 12 hours later, Z1 was notified again concerning R1's skin status. Z1 was advised that R1 continued to have a rash to her abdominal folds and groin with open areas on her abdomen. Z1 ordered stat labs and Prednisone to be given over a 3 day period.

The record contains no further Nurse's Notes until 1/17/06 at 8:00 AM, when the Wound Care Nurse informed staff that R1's abdomen and upper thighs were bright red, the skin was warm and skin folds were peeling away. The notes document that the abdominal folds had 'copious amounts ' of bright red blood with large clots. R1 was described as screaming in pain. There was no documented assessment or follow-up concerning R1's skin status until Z1 was called (18 hours later.)

R1's Emergency Room Report dated 1/17/06 documents that R1.... "presented from the nursing home with, what appeared to be, cellulitis over her right leg and much of her abdomen. She states the symptoms have been worsening over the past week."

R1's Emergency Room Patient Notes dated 1/17/06 at 9:00 AM document, "Patient (R1)...is alert, complaint of large areas of burn like skin to abdomen and legs, sores to mouth and both legs. Complaint of pain and micro areas of bleeding from skin...."

During a confidential interview conducted on 6/2/

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145908	A. BUILDING _____ B. WING _____	C 06/08/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AMBERWOOD NURSING & REHAB CENTER	**2313 NORTH ROCKTON AVENUE ROCKFORD, IL 61103**

(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	Continued From page 38 06 at 9:50 AM, staff verified with the surveyor that nursing documentation and assessment of R1's skin status was not consistent. Nursing staff verified that there was no evidence that the physician had been notified concerning R1's skin condition prior to 1/15/06 at 1:00 AM. The staff interviewed stated that the physician should have been notified of the excoriation to the abdominal folds and groin on 1/12/06. This staff also verified that the moist red groin area as noted on the facility's Nursing Admission Form was not treated or assessed for 13 days. During a phone interview on 6/5/06 at 10:05 AM, Z2 (Primary Physician) was asked by the surveyor if he felt that the facility neglected R1's care. Z2 responded "yes." (A) 300.1210b)4) 300.1210b)6) 300.3240a) Section 300.1210 GENERAL REQUIREMENTS FOR NURSING AND PERSONAL CARE b)4) Personal care shall be provided on a 24-hour, seven daya week basis. b)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.	F9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145908	A. BUILDING _____ B. WING _____	C 06/08/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AMBERWOOD NURSING & REHAB CENTER	**2313 NORTH ROCKTON AVENUE ROCKFORD, IL 61103**

(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	Continued From page 39 Section 3240 ABUSE AND NEGLECT a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. I. Based on interview and record review the facility failed to assure the safety of a resident (R 22) with moderate mental retardation and significant medical history. The facility did not have measures in place to assure that R22 was safe after verbalizing several times on 5/28/06 his desire to leave the building. The resident was found by staff walking along a busy four lane street 15 minutes after it was realized he was not in the building. He was returned to the facility. II. Based on observation, record review and interview the facility also failed to supervise and monitor the whereabouts of a resident (R24) who had taken a shower and fallen in the shower room on 5/30/06. The resident was found unresponsive and was unable to be resuscitated. III. Based on interview and record review the facility also failed to supervise a resident (R28) while smoking ,to ensure the safety of the resident as well as the residents who reside at the facility. The findings include: I. R22, according to the facility's Temporary Admission Care Plan dated 5/28/06, is a 47 year old male resident with the following diagnoses: End Stage Renal Disease, Hemodialysis, Mental Retardation, Hypertension, Seizure Disorder, and Systemic Lupus Erythema.	F9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145908	A. BUILDING _____ B. WING _____	C 06/08/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AMBERWOOD NURSING & REHAB CENTER	**2313 NORTH ROCKTON AVENUE ROCKFORD, IL 61103**

(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	Continued From page 40 The elopement assessment for R22 dated 5/28/06 states that R22 is not an elopement risk. There were no precautions put into place to monitor the resident's whereabouts. Review of hospital records for 12/20/05 documents that R22 is on Hemodialysis, with a history of a Seizure Disorder, Hypertension, Medical Noncompliance, Systemic Lupus Erythematosus, Polysubstance Abuse and Dependence, Mental Retardation, and Chronic Progressive ataxia. R22 was seen at the Emergency Department five times between 1/1/06 and 5/25/06 for altered mental status, syncope, seizure activity, and falls. R22 was in the Emergency Department on 5/25/06. According to Case Management documentation for 5/25/06 R22 was seen by a Case Manager to begin the process of placement into a skilled nursing facility. R22 told the Case Manager that things were tough at home. His mother is ill. He isn't functioning well. The Adult Case Management Assessment dated 5/26/06 documents R22's chief complaint as having " fainted at dialysis. Has not been eating." R22 requested he be admitted to a skilled nursing facility on the west side of town. R22 was admitted to the facility on 5/28/06 at 1:50 PM. According to the admission Nurse's Notes R22 was alert and responsive with some confusion noted. According to nurses documentation, R22 told E14 (RN, Assistant Director of Nursing) that he was not going to stay in the facility.	F9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145908	A. BUILDING _____ B. WING _____	C 06/08/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AMBERWOOD NURSING & REHAB CENTER	**2313 NORTH ROCKTON AVENUE ROCKFORD, IL 61103**

(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	Continued From page 41 On 6/26/06 at 12:50 PM E13 (Director of Nursing) stated that she counseled the resident about his medical conditions and why it was in his best interest to stay at the facility. She told the resident if he decided to leave the facility he would need to sign a form stating he was leaving against medical advice. R22 did sign a Release From Responsibility For Discharge form. E13 documents in the Nurse's Notes that at 2:50 PM on 5/28/06 the "resident chose to stay." Record review of nursing documentation shows that at 5:35 PM the staff was not able to locate R 22. A building search was initiated. The resident was not in the building. During an interview with E13 (DON) she was asked how long a staff member is at the reception desk. It was stated that the receptionist is at the desk until 8:00 PM. An interview with E13 (DON) on 6/2/06 at 12:50 PM verified the nursing documentation that R22 was seen by a nursing assistant at 5:45 PM walking by a junior high school. The resident was 3 1/2 blocks from the facility. The resident crossed a very busy four lane road. The temperature at 5:54 PM was 91 degrees Farenheit (per wunderground.com., history for Rockford, Illinois on Sunday, May 28, 2006). The resident was returned to the building at 5:50 PM on 5/28/06. There was no physical assessment done on the resident after returning to the building. Record review shows a "Summary documentation" in the Nurse's Notes dated 5/29/ 06 at 7:15 AM. It is documented that the " resident was ambulating through the building. Social Service explained to resident that he had signed himself AMA (against medical advice) and	F9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145908	A. BUILDING _____ B. WING _____	C 06/08/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AMBERWOOD NURSING & REHAB CENTER	**2313 NORTH ROCKTON AVENUE ROCKFORD, IL 61103**

(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	Continued From page 42	F9999		

he needed to leave the building."

On 6/2/06 at 12:50 PM E13 (DON) stated the resident walked home. He had signed out AMA (Against Medical Advice). The resident's home is 2.7 miles from the facility, according to "Yahoo! Maps, Driving Directions, and Traffic."

Review of the facility's policy for "Discharge Against Medical Advice" states the purpose of the policy is to "ensure safe departure from health facility when it is without medical approval ." Listed under procedures is to "give any appropriate instructions to Resident and instruct to contact physician immediately. Document instructions given on record." At 12:50 PM on 6/2 /06 E13 (DON) verified the policy was not followed. There are no discharge instructions documented in the resident's medical record.

On 6/2/06 at 10:35 AM R22's mother was interviewed. She said that her son was mentally handicapped. When asked if she was ever told his developmental age, she said, "No, but he's pretty bad." She was asked if he ever goes places alone. She said he is not supposed to but he will sneak off.

On 6/2/06 at 12:30 PM Z 9 (physician) stated he knew R22 very well. When speaking with the resident you need to speak in basic terms. I do not know his developmental age. He is not able to care for himself, he needs assistance.

On 6/2/06 at 4:00 PM Z10 (physician) was asked about R22's safety and survival skills in the community, his developmental age, and R22's need for supervision. Z10 said he does not

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145908	A. BUILDING _____ B. WING _____	C 06/08/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AMBERWOOD NURSING & REHAB CENTER	**2313 NORTH ROCKTON AVENUE ROCKFORD, IL 61103**

(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	Continued From page 43	F9999		

function very well. His developmental age is probably in the adolescent range. R22 does require supervision.

II. R24 has diagnoses that include Congestive Heart Failure, Hypothyroidism, Dementia with Aggression, Degenerative Joint Disease and Depression per review of the Physician Order Sheet (POS) dated May, 2006. R24 had an order for a full code.

R24's assessment dated 5/12/06 shows R24 had short term memory problem and modified independence for decision making in cognitive skills; functional limitation in both lower legs/hips or knees; partial functional loss in both lower extremities and used a cane for ambulation.

Review of R24's Nurse's Notes of 5/30/06 at 1530 state, "R20 was observed on the floor in (the) shower room."

On 6/01/06 at 2:25 p.m. E22 (CNA) stated, "R24 has always had a problem with him taking a shower. R24 comes in and gets out of his clothes . He walked down to the shower and I went with him to the shower. R24 was getting dressed at 2: 35 p.m.- 2:40 p.m. I left him in the shower room. I was getting ready to go and I passed this on to E15 (CNA). E15 was at the (nurses) desk."

On 6/01/06 at 3:15 p.m. E15 was interviewed. E 15 stated, "I was coming on 2nd shift. I did not know R24 had had a shower and was left dressing in the shower room. In report the nurse said R24 did not want a shower. I did get report from E22 but she did not tell me that R24 was

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145908	A. BUILDING _____ B. WING _____	C 06/08/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AMBERWOOD NURSING & REHAB CENTER	**2313 NORTH ROCKTON AVENUE ROCKFORD, IL 61103**

(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	Continued From page 44 dressing in the shower room. R24 would have been my patient and he was always in his room when I come to work. E21 (CNA) was there." On 6/01/06 at 3:30 P.M. E21 was interviewed. E 21 stated, "When I came on the floor I did not see R24 and that was unusual. I didn't hear anyone say that R24 was in the shower room. If I knew R24 was in the shower I would have checked on him first." Review of R24's care plan of 3/20/06 for dressing states R24 has decreased motivation due to Dementia; for bathing R24 has decreased motivation due to Dementia and Depression and for falls there are approaches to encourage and instruct him to wear shoes and provide non-slid socks. R24's care plan states has impaired vision and does not want to wear glasses and has increased pain in knees. (R24 had knee injected for pain on 4/26/06). R24's care plan does not address any need for supervision or monitoring during shower or dressing in shower room even though R24 had impaired vision, partial loss of functioning in lower extremities, used a cane for ambulation, and had a short term memory problem. R24's care plan stated he was to wear shoes, wear non-skid socks and was to receive assistance with activities of daily living due to "impaired vision." R24 fell in the shower room on 5/30/06 and was not seen by staff from 2:30 -2:40p.m. until 3:30-3: 40pm when he was found in the shower room, where he expired. The shower room where R24 had fallen and where R24 expired was observed on 6/01/06 with E18 (LPN) and E14 (ADON).	F9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145908	A. BUILDING _____ B. WING _____	C 06/08/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AMBERWOOD NURSING & REHAB CENTER	**2313 NORTH ROCKTON AVENUE ROCKFORD, IL 61103**

(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	Continued From page 45 There was an outer door to the shower room and an inner room. The area where R24 was found was a small alcove within the shower room. The small alcove was approximately 2 feet wide by 5-5.5 feet long. R24 was approximately 6 feet tall. When emergency medical services had their first contact with R24 at 1549, R24's body was cold. III. R28 is a 77 year old cognitively impaired female resident who has the diagnoses of History of Alcohol Abuse, Organic Brain Disorder, and Delusional Disorder as per the June 2006 Physician Order Sheet. R28's assessment for 5/5/06 states that the resident is moderately impaired in cognitive skills for daily decision making. She has periods of altered perception or awareness of surroundings. Review of Social Services documentation shows that R28 has had numerous issues with the smoking policy. On 3/15/05 the resident was counseled regarding asking other residents for cigarettes in the smoking room. On 6/23/05 the resident is documented as smoking inappropriately in the smoke room and was counseled on the smoking rules. On 6/27/05 R28 was in possession of a lighter and cigarettes. The Care Plan for R28 on smoking, dated 2/8/06. documents that the resident has been found with smoking materials. The approaches to the care plan are that when the resident is found to have smoking materials it will be explained to her that smoking materials need to be kept locked up, staff will periodically check the resident's room for	F9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145908	A. BUILDING _____ B. WING _____	C 06/08/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AMBERWOOD NURSING & REHAB CENTER	**2313 NORTH ROCKTON AVENUE ROCKFORD, IL 61103**

(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	Continued From page 46	F9999		

smoking materials, quarterly smokers assessments will be done and monitor resident while smoking for alterations in her smoking safety.

The Smoker Assessment for R28 dated 2/16/06 is incomplete. It states that the resident is alert and oriented and that she has followed the facility's smoking policy in the past. The assessment does not state whether the resident is unstable or a suitable candidate for unsupervised smoking.

On 6/7/06 at 1:00 PM E6 (LPN) stated it has been thought that at times R28 has smoked in the shower room but no one has ever caught her. Smoking materials have never been found in her room, she probably keeps them with her, possibly in the tissue box she always carries.

On 6/7/06 at 1:30 PM E24 (Activity Director) stated that one of her assistants had witnessed R 28 putting a lit cigarette out inside of a tissue box.

On 6/7/06 at 1:30 PM E 23 (Social Service Director) stated she saw a lighter in R23's tissue box which she carries with her at all times. The resident refused to let her look into the box. She also saw her going through the garbage and ash trays outside in the courtyard looking for cigarette butts.

On 6/7/06 at 2:00 PM E25 (Assistant Administrator) was asked why R28's smoking habits were not addressed before this week. He said that R28's behaviors began escalating the past 3-4 weeks.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145908	A. BUILDING _____ B. WING _____	C 06/08/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AMBERWOOD NURSING & REHAB CENTER	**2313 NORTH ROCKTON AVENUE ROCKFORD, IL 61103**

(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	Continued From page 47 (A)	F9999		