STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145811	A. BUILDING ______ B. WING ______	C 07/21/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROSE GARDEN CONVALESCENT CTR	**1629 GARDNER LANE** **PEORIA HEIGHTS, IL 61614**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED 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 314	Continued From page 20 The treatment sheet does document the following : "Left Foot Top, cleanse with NS (Normal Saline), pat dry, TAO (Triple Antibiotic Ointment), Nonadherent dressing with Kerlix wrap daily and PRN." 2. R1 is a 63 year old female resident with diagnoses of Sepsis, Decubitus Ulcer, History of Cerebral Vascular Accident, and End Stage Renal Disease per current Physician's order sheet dated 6/30/06. Observation of R1 on 7/3/06 at 11:40 AM noted her in bed awake but not alert to her name. E3, ADON (Assistant Director of Nursing) was present to position resident to view pressure sore areas. R1 had dressings on her left and right hip both dated 6/28/06 and one dressing to her right lower leg dated 6/27/06. R1 had a large pressure sore on her coccyx with no dressing on it. The coccyx wound was foul smelling and yellow/ brown drainage was noted on the incontinent pad . Physician's order and Treatment record dated 6/ 30/06 documents the following: "Cleanse wounds daily with NS (Normal Saline) pat dry and apply tender wet daily with 'dressing'."	F 314		
F9999	FINAL OBSERVATIONS LICENSURE VIOLATION 300.610a) 300.3240a) 300.3240b) 300.3240d) 300.3240e)	F9999		

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F9999	Continued From page 21 300.610 Resident Care Policies a) The facility shall have written policies and procedures, governing all services provided by the facility which 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 serivces in the facility. These policies shall be in compliance with the Act and all rules promulgated thereunder . These written policies shall be followed in operating the facility. 300.3240 Abuse and Neglect a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. (Section 2-107 of the Act) b) A facility employee or agent who becomes aware of abuse or neglect of a resident shall immediately report the matter to the facility administrator. (Section 3-610 of the Act) d) A facility administrator, employee, or agent who becomes aware of abuse or neglect of a resident shall also report the matter to the Department. (Section 3-610 of the Act) e) Employee as perpetrator of abuse. When an investigation of a report of suspected abuse of a resident indicates, based upon credible evidence, that an employee of a Long-Term Care facility is the perpetrator of the abuse, that employee shall immediately be barred from any further contact with residents of the facility, pending the outcome of any further investigation, prosecution or disciplinary action against the employee. (Section 3-611 of the Act)	F9999		

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F9999	Continued From page 22 These requirements are not met as evidenced by : Based on interviews, observations, and record review the facility failed to prevent the physical abuse of one resident (R6). A staff witness to the abuse failed to intervene and protect the resident. The incident was not reported immediately to administrative staff. The facility failed to follow their Abuse Prohibition Policy by allowing staff to continue to work after this incident of abuse. The facility failed to conduct a thorough investigation and did not report the incident to the Illinois Department of Public Health. Findings include: R6 is a 46 year old male resident with diagnoses of Paraplegia, Osteomyelitis of Right Hip, Anxiety, Diabetes Mellitus, and Arthritis per current Physician's order sheet of July 2006. MDS (Minimum Data Set) dated 7/10/06 documents that R6 has 'modified independence' regarding cognitive skills for daily decision-making. On 7/17/06 at 6:45 PM R6 approached surveyor and reported an incident of abuse between himself and a nurse. R6 was noted as wheelchair bound and uses an electric wheelchair to independently move about the facility. At 7:10 PM on 7/17/06 R6 was interviewed outside on the patio. R6 stated the following, "Last Monday night (7/10/06) I asked (E4), LPN (Licensed Practical Nurse), to connect my IV (Intravenous) medication. I asked her to wash her hands and wear gloves. She got mad and we argued back and forth. (E4) pointed syringe packets in my face, I pointed my fingers	F9999		

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F9999	Continued From page 23	F9999		

at her and she grabbed them, pulled them down and twisted them. It pissed me off, no one is going to do me like that. Another nurse (E5), LPN, was there, she knows what she (E4) did to me. I've got my mind, what if I was one of these old people in here. The DON (Director of Nursing), E2 told me that they reprimanded her, (E4). The next day or so, (E1), Administrator, said that they were still working on it."

Interview with E5, LPN on 7/17/06 at 9:00 PM stated the following: "I had taken over IV tubing to East wing around 10:30 PM last Monday (7/10/06). R6 and E4 were getting into it at the nurses station (arguing). (E4) had a syringe and pointed it in his face (R6). (R6) pointed his finger at her (E4). (E4) grabbed his finger real hard. She (E4) grabbed his IV tubing, both were grabbing stuff off the counter. (R6) went to his room very angry . A few minutes later I went to (R6's) room, he said "she was abusive to me." (R6) asked me if I did anything wrong. I told him that he shouldn't have cussed at her (E4). I agreed with (R6) that she was abusive. (E4) instigated the fight. (R6) can be very demanding and swears at staff a lot, but you can't treat any patient like that. (E4) called E1, Administrator, that night and told me that she (E1) was going to talk to me. (E2), DON (Director of Nursing) told me to write out a statement which I haven't done yet. No one has talked to me yet."

Interview with E4, LPN, on 7/17/06 at 10:10 PM stated the following: "Last Monday around 10:20 PM I worked third shift on the East wing. (R6) started in with cussing right away. He wanted his IV medications right away. He refused his Flagyl and wanted his Vancomycin first. Both medications had been set out of the refrigerator

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F9999	Continued From page 24 by another nurse. He (R6) was calling me a fat 'b ----.' He was accusing me of putting the IV's in the freezer. He took off to the TV room. (R6) came back to the nurses station and accused me again of putting the Flagyl in the freezer. I had his flush (syringe with normal saline) ready to go. He grabbed the Flagyl bag (pre-mixed IV bag). I grabbed the flush and told him he's not doing his IV and that's my license. After grabbing the Flagyl bag (R6) pointed his finger in my face and I pulled it away. I was standing at the corner of the nurses station. I had the syringe in my hand but I did not shake it in his face. I grabbed his finger as a reaction I don't know why. After the incident I knew that I should not have grabbed his finger. I talked to E2, DON, and she told me to write out a statement and she gave me a verbal warning. I called E1, Administrator, right away after the incident. I told her what happened and she told me to chart everything. I continued to work that night until 6:15 AM or so. I don't know if any one has written up an incident report. No one has given me any restrictions regarding the care of (R6)." The following is a written final report of the incident investigation involving R6. The report was written by E2, DON: "7/11/06 Reported to me by the administrator on early morning of 7/11/06 that (R6) had become aggressive with nurse (E4) . Upon entering the facility early morning 7/11/06 this DON read the charting concerning the prior night's events concerning (R6). Attempted to call (E4) without success. This DON then spoke with resident (R6) when he returned to the facility. (R6) stated that said nurse tried to administer frozen cold IV solutions and tampering with the solutions and NS (Normal Saline) flush. Upon speaking with	F9999		

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F9999	Continued From page 25 LPN (E4), I had her write up her statement of events for the evening of July 10, 2006 at 11:30 pm with resident (R6). (E4) gave her written statement stating that the IV's were already taken out of the refrigerator and the solutions were not frozen. And that said resident accused her of tampering with his IV solutions. She also stated that said resident was being verbally abusive to her, which is common for said resident. She stated that yes resident did shake fingers very closely in her face and yes she pushed his fingers away with her hand. I counseled said LPN stating that it was very inappropriate to push resident's hand away like that and did give said nurse a write up because she used her hand and not her forearm to remove his fingers from her face. She was counseled for improper technique on her part. In speaking with the other nurse, (E5), who witnessed the situation she did state that she felt (E4)'s actions were "inappropriate" however, she did state that (R6) was being " verbally aggressive with (E4)." I requested that (E5) put her statement of this event into writing and give it to this DON. Upon speaking to those involved, we feel that there was no willful intent to harm resident and nurse was acting in a reactionary manner to the resident's verbal and physical aggression." Interview with E1 (Administrator), on 7/20/06 at 9: 05 AM corroborated the above written report by E 2, DON. E1 stated that she was aware of its content and was involved in the decision making regarding the outcome of this incident. E1 did not follow the facility's Abuse Policy by initiating an investigation (i.e. interview R6/ witnesses, protect R6 from further abuse, notify R 6's physician/representative). E1 states that she	F9999		

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F9999	Continued From page 26	F9999		

did not report the incident to the Illinois Department of Public Health because the facility's investigation did not result in abuse.

Current care plan dated 7/12/06 lists the following under approaches for 'cognitive deficit':
"If resident is being resistive, rude, demanding with verbal insults, excuse yourself for a few minutes and re-approach. Approach in a non-judgmental manner. Speak in a calm voice. Don't take his comments personally. Don't confront resident."

The facility's Abuse Prevention Program states the following:

1. Supervisors shall immediately inform the administrator or designee of all reports of potential mistreatment. Upon learning of the report, the administrator or designee shall initiate an incident investigation.
2. Employees of this facility who have been accused of mistreatment will be removed from resident contact immediately until the results of the investigation have been reviewed by the administrator or designee. Employees accused of possible mistreatment shall not complete the shift as a direct care provider to residents.

Nursing schedule documents that E4 worked 7/13/06 and 7/17/06 in addition to working her entire shift the night of the incident involving R6.

(A)