STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145980	A. BUILDING _____ B. WING _____	02/16/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROSEWOOD CARE CENTER OF ST CHARLES	**850 DUNHAM RD ST CHARLES, IL 60174**

(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
F9999	FINAL OBSERVATIONS LICENSURE VIOLATIONS: 300.690a)1)2) 300.3240b) 300.3240e) Section 300.690 Serious Incidents and Accidents a) The facility shall notify the Department of any incident or accident which has, or is likely to have, a significant effect on the health, safety, or welfare of a resident or residents. Incidents and accidents requiring the services of a physician, hospital, police or fire department, coroner, or other service provider on an emergency basis shall be reported to the Department. 1) Notification shall be made by a phone call to the Regional Office within 24 hours of each serious incident or accident. If the facility is unable to contact the Regional Office, notification shall be made by a phone call to the Department's toll-free complaint registry number. 2) A narrative summary of each accident or incident occurrence shall be sent to the Department within seven days of the occurrence. Section 300.3240 Abuse and Neglect 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) e) Employee as perpetrator of abuse. When an investigation of a report of suspected abuse of a	F9999		

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F9999	Continued From page 70 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) These REGULATIONS are not met as evidenced by: Based on observation, interview, and record review, the facility failed to: 1) Thoroughly investigate the circumstances (CNA did not report injuries-shower given 2/7/07) related to incidents involving two residents (R10, R20) with injuries of unknown origin which resulted in untreated pain and possible fracture. 2) Thoroughly investigate allegation of abuse for 2 residents (R26 and R21). 3) Immediately notify proper staff of alleged allegation of abuse and injuries of unknown origin. This is for two residents (R10 and R20) with injuries of unknown origin and two residents (R26 and R21) alleged to have been abused. The findings include: 1. On 2/8/07 at 10:30 am during a pressure sore dressing change, surveyor observed R10's right knee with two yellowish bruises measuring 4.0 X 4.0 cm. and 1.0 X 1.5 cm. Bluish bruising with swelling was also noted under right knee measuring 18 cm. X 11cm. R 10's left knee had 1 yellowish bruise measuring 1.0 X 1.0 cm.	F9999		

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F9999	Continued From page 71 Interview with E3 (wound nurse), E3 stated she did not know about the bruises. Review of E3's wound documentation sheets to be completed with an assessment weekly documented E3 on 1/30/07, no further assessments documented. Review of R10's nursing notes document she complained of leg pain on 1/30/07 to Z1 (hospice nurse). Ibuprofen 400 mg. ordered by Z1, but the facility did not administer a dose until 2/1/07 at 8:45 am after complaints of leg pain. Another dose of Ibuprofen 400 mg. was not administered until 2/8/07. Every day of the survey R10 complained to surveyor of leg pain. Observations throughout the survey R10 was observed with long, dirty fingernails, dirty hair, urine stained clothing, and strong urine odors. On 2/8/07 at 10:00 am, R10 was observed having a strong urine odor. At 1:15 pm during a complete body assessment, surveyor observed R10 having a urine stained shirt on and smelled of strong urine odor. R10's most recent Minimum Data Set (MDS) dated 12/20/06 shows R10 needs total assistance with one person physical assist in the areas of personal hygiene and bathing. Review of R10's Resident Assessment Protocol (RAP) - ADL functional/rehabilitation potential dated 12/20/06 documents "R10 triggers in this area due to extensive assistance with bed mobility, transfer, dressing, total dependence in staff for locomotion on/off unit, toilet use and personal hygiene. Possible causes/factors include diagnosis of Parkinson disease/decline in ADL status." Interview with E4 (cooperate nurse) on 2/9/07 at	F9999		

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F9999	Continued From page 72 2:00 pm, surveyor asked for R10's shower record/skin audit. E 4 stated the facility has documented one shower given 2/7/07 (no injuries noted) by E12 (CNA). The facility does not have additional documentation regarding R10's shower/baths because Hospice provides R10 showers/baths. R10 was admitted to Hospice care on 1/3/07. Documentation submitted to surveyor regarding information when Hospice direct care staff (Z2) provided personal care to R10 documents: bath given and skin intact on 1/26/07, 1/31/07, and 2/7/07 (no injuries noted). Interview with E4 (cooperate) on 2/9/07 during the daily status meeting at 5:00 pm stated "an in house x-ray was done on 2/8/07 at 4:00 pm; it was negative-no fracture." Review of x-ray form completed on 2/8/07 presented to survey team on 2/9/07 documents R10 does not have a fracture. Interview with Z1 on 2/9/07 at 11:00 am, Z1 stated she assessed R10 on 1/30/07 and R10 did have the bruising to her legs, but she did not tell anyone. R10 complained about leg pain, so she called the doctor and he ordered Ibuprofen 400 mg. but she did not administer any dosages. The facility and Hospice have not had a care plan meeting to integrate R10's plan of care. Hospice has a separate plan of care. The assessment was completed by talking with the facility staff. 2. R20 was admitted to the facility on 1/14/07. Review of the facility's admission nursing assessment documents R20 is dependent on staff for shower, shampoo, toilet use, and oral care. R20 needs assistance in the areas of grooming, toilet use, and dressing. R20's most recent Minimum Data Set (MDS) dated 1/22/07	F9999		

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F9999	Continued From page 73 shows R20 needs extensive assistance with one person physical assist in the areas of personal hygiene and bathing. Review of R20's Activities of Daily Living (ADL) personal hygiene forms/shower forms dated 1/15/07 through 2/5/07 documents R20 has not been bathed since admission to the facility. Review R20's shower record/skin audit documents on 1/18/07 shower given; 1/22/07, R20 refused. R20 was observed throughout the survey with a blue, black bruise under her left eye. Surveyor asked E2 (DON) what happened to R20's eye, and she stated the facility did an incident report on 2/4/07 but she has not had time to do an investigation. The facility figured the bruising was from her glasses, but they were not positive. Part of the facility's corrective plan was to assess all residents for unknown injuries. Assessment completed on the midnight shift. Nurse (E20) on 2/9/07/-2/10/07 with findings of three new unknown bruises: 1) one noted to right mid back measuring 2.0 cm. X 2.5 cm. in diameter. 2) one to right lower arm in diameter measuring 3.0 cm. X 2.0 cm.. 3) bruising to right upper arm measuring 4.5 cm. X 2.5 cm. in diameter. Interview with E1 (Administrator) on 2/10/07 during the morning daily status report stated "the facility did not know about R10's bruises or R20's bruises, so we did not do investigations or report the injuries of unknown origin to Illinois Department of Public Health, but we will now."	F9999		

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F9999	Continued From page 74 Review of the abuse current policies and procedures for this facility document that "The Administrator serves as the Abuse Prevention Coordinator and is responsible for the coordination of investigations in allegations of abuse or neglect. It is everyone's responsibility to report suspicions of neglect or abuse to the Abuse Prevention Coordinator immediately. The facility's abuse policy and procedure showed, "The nursing staff is responsible for reporting on a facility report the appearance of bruises, laceration, or other abnormalities as they occur. Skin tear tears and bruises of unknown origin are to be investigated." 3. Review of incident report dated 7/3/06 indicates that one CNA (E14) reported that another CNA (E13) handled a resident in a rough manner. The CNA in question (E13) has not had any further contact with this resident. This investigation is on-going at this time. The follow-up dated 7/10/06 indicates the CNA in question chooses to resign rather than give a statement. Unable to verify, resident unable to say what happened, no other guest with complaints of rough treatment from this CNA. This incident file had a written statement from E14 stating that while helping her with care, E13 stepped firmly on R21's foot and grabbed her ankles and shoved them back onto the bed. According to E14, E13 grabbed R21's feet and pushed them down against the footboard repeating "who's in control now." Interview with E2 on 2/10/07 indicated that the facility could not get in touch with E13 after this incident because they did not have correct phone numbers and addresses. E2 said that she	F9999		

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F9999	Continued From page 75 believed that E14 was not credible in this allegation. E13 was re-hired as a CNA this past month, and no further investigation was done. 4. Review of most recent physician order sheet for the current month of February 2007, R26 is 98 years old with diagnosis including depressive disorder, hypertension, congestive heart failure, stroke and diverticulitis. Observation and interview with R26 found her to be sitting at the dinning table in a wheelchair on 2/10/07 at 12:30pm. R26 was alert and orientated to self and pleasant. Review of documents from an alleged abuse occurrence against R26 were reviewed. Per the only interview in the file dated 8/8/06, the nurses aide making the statement states that R26 informed her (CNA) at 3:15 pm that "a man" slapped her (R26) in the face during continence care the night before. R26 could not say who the man was. This statement does not say that the nurses aide went and immediately reported this allegation to the proper staff. The statement goes on to say that it was not until later the same day, after dinner, when R26's granddaughter approached the same nurses aide and told the aide that R26 had reported to to her that she (R26) had been slapped the night before. Surveyor requested all paperwork compiled during the facility investigation of abuse against R26 on 8/8/06. There was no documentation regarding this allegation that the facility had interviewed or followed through with who had been the aides on duty during the night in question and caring for R26. The remainder of the investigation states that	F9999		

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F9999	Continued From page 76 R26 mentioned that the alleged abuser may have thought he was whacking a fly and didn't mean to hit her. A letter from R26's daughter regarding the incident/investigation conveys that perhaps R26 does not want to rock the boat for fear of reprisals. ..."Whatever you can do to ensure Mom's safety and allay her fear of retaliation will be greatly appreciated." (A)	F9999		