STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145891	A. BUILDING ______ B. WING ______	C 09/27/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROSEWOOD CARE CENTER OF ROCKFORD	1660 SOUTH MULFORD ROCKFORD, IL 61108

(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 514	Continued From page 19 nurse will be responsible for assessing the guest's condition on a continual basis. The wing nurse will notify the physician and family of any significant change in the guest's condition at the time the change is noted. Changes in a guest's condition will be documented in the progress notes of the chart and on the 24 Hour Daily Log each shift." The facility's Charting and Documentation Guidelines Policy dated 8/00 states, "Nurse's notes should include but are not limited to: Changes of condition including symptoms, complaints, vital sign changes, etc; Symptoms complained of by the guest; Change in temperature, pulse and respiration; and Unusual conditions of body discharges."	F 514		
F9999	FINAL OBSERVATIONS LICENSURE VIOLATIONS 300.610a) 300.1210a) 300.1210b)3) 300.3240a) Section 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 services 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 and shall be reviewed at least annually by this committee, as evidenced by	F9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145891	A. BUILDING ______ B. WING ______	C 09/27/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROSEWOOD CARE CENTER OF ROCKFORD	1660 SOUTH MULFORD ROCKFORD, IL 61108

(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	Continued From page 20	F9999		

written, signed and dated minutes of such a meeting.

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.
b) General nursing care shall include at a minimum the following and shall be practiced on a 24-hour, seven day a week basis:
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 300.3240 Abuse and Neglect
a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident.

These Requirements are not met as evidenced by:

Based on interview and record review the facility staff:
1) Failed to assess and provide timely care after a CNA repeatedly reported R1's symptoms of abdominal pain to the nurse. R1 was in severe pain for 9 hours before being sent to the hospital

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145891	A. BUILDING ______ B. WING ______	C 09/27/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROSEWOOD CARE CENTER OF ROCKFORD	1660 SOUTH MULFORD ROCKFORD, IL 61108

(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	Continued From page 21	F9999		

for evaluation and treatment. R1 expired at the hospital related to sepsis and GI (gastrointestinal) bleed.

2) Failed to give R2 an ordered antibiotic medication for 28 hours and failed to contact the physician regarding a resident with a change in condition beginning on 9/14/07 at 3:30 PM. R2 was admitted to a local hospital on 9/14/07 at 8:00 PM, after experiencing shortness of breath for 5 hours. R2 was admitted with the diagnosis of Pneumonia. The nurse on duty had failed to assess R2 after CNAs reported to her on several occasions that R2 was having difficulty breathing. CNAs finally alerted a different nurse.

3) Failed to thoroughly assess a resident's (R3) right knee surgical wound. R3 was admitted to a local hospital on 9/15/07 with Cellulitis of the right knee.

4) Failed to ensure that R5's increase in pain was evaluated to determine the cause of the pain and to monitor a R5's fluid intake. R5 was on a fluid restriction of 1500 cc's of fluid per day.

Findings include:

1) R1 has diagnoses of Breast Cancer, Diabetes Type II, Neurogenic Bladder, Hypercarbic Respiratory Failure, Asthma, Restrictive Lung Disease, Hyperkalemia, and Pre Renal Failure per the Physician's Order Sheet for August 2007. The resident assessment of 7/14/07 documents that R1 is continent of bowel and bladder. R1 has no memory deficits and is able to communicate her needs to staff.

On 9/20/07 at 3:15 PM, E6 (CNA) said that R1 first started complaining of abdominal pain around 3:00 PM on 8/19/07. "It was obvious she was in pain. R1 was pale, sweaty, and could not

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145891	A. BUILDING ______ B. WING ______	C 09/27/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROSEWOOD CARE CENTER OF ROCKFORD	1660 SOUTH MULFORD ROCKFORD, IL 61108

(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	Continued From page 22	F9999		

keep her eyes open. I told E13 (LPN) about R1's abdominal pain 3 to 4 times during my shift. The last time I approached E13 about R1 was at 10:00 PM during shift change. E13 told me that there was nothing else we could do for her. You could tell there was something wrong. There have been so many cases lately where you would tell E13 something was wrong and E13 would say it is just behavior. R1 was crying and saying she wanted to die because of the pain. R1 was on her call light every 5 minutes during the evening shift with repeated complaint of severe abdominal pain."

On 9/20/07 at 2:35 PM, E13 (LPN) stated, "I gave her a pain pill around 8:30 PM for generalized pain. I also gave her Milk of Magnesia for constipation. I did not think that she was sick enough to send out. I do not recall if I assessed her abdomen or took vitals. I was concerned that she did not feel well. R1 was always complaining. On my way home that night I called back to the facility and asked the nurse to check on her. I knew something was going on. I thought it might have been her gallbladder. I guess I should have documented something on my shift."

On 9/21/07 at 9:30 AM E5 (Agency LPN) stated, "E13 did not document anything concerning R1 on 8/19/07 for the evening shift. E13 told me she had an upset stomach. E13 was not able to tell me anything concerning why R1 was having abdominal pain. I do remember E6 approaching E13 during shift report and telling her something was wrong with R1. I was concerned and when I went down to R1's room she was not responding well and her abdomen was very distended. The RN working on the night shift told me to send her out."

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145891	A. BUILDING ____ B. WING ____	C 09/27/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROSEWOOD CARE CENTER OF ROCKFORD	1660 SOUTH MULFORD ROCKFORD, IL 61108

(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	Continued From page 23	F9999		

On 9/21/07 at 9:00 AM E4 (RN) said I told E5 to send her out on 8/20/07. R1 was very pale and cool to touch. The nurse (E13) said that R1 was complaining of generalized pain. R1 was full of stool when E5 checked her. The CNA's said that this had been going on the entire second shift. Her DNR (Do Not Resuscitate) order was not signed by a physician. The ambulance driver was banging on the facility door wanting to confirm R1's code status. The ambulance driver was concerned that R1 may arrest in the ambulance during transport.

R1's Narrative Nurse's Progress Notes show that there was no documentation for the evening shift on 8/19/07. On 8/20/07 at 12:20 AM the Progress Notes state, "Upon Nurses Assessment at this time noted resident cool to touch, crying stating 'My stomach hurts my bowel hurts', asked if she had a bowel movement stated, 'I can't' checked for impaction large dark brown hard stool blocking the rectum, removed stool moderate to large amount. Guest able to at this time to go on her own, expelled extra large amount of dark brown loose stool. No complaint of any pain, blood sugar checked and was 148, remains cool to touch. O2 saturation at 89%, Blood Pressure 116/62, respirations 18, pulse 68, temp 93.9...Head of bed elevated and O2 being administered..." The facility received physician orders to send R1 to the hospital at 1:00 AM. R1 left the facility by ambulance at 1:15 AM.

The Hospital Emergency Nursing Record dated 8/20/07 documents that R1 was pale, cyanotic, disoriented to place and time, abdominal tenderness with hypo-active bowel sounds. R1's skin was dusky (cyanotic) around the mouth with

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145891	A. BUILDING ________ B. WING ________	C 09/27/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROSEWOOD CARE CENTER OF ROCKFORD	1660 SOUTH MULFORD ROCKFORD, IL 61108

(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	Continued From page 24	F9999		

generalized mottling over the entire body. The Medical History and Physical/Death Summary dated 8/20/07 states, "Sepsis in a patient with probable upper GI (gastrointestinal) bleed." R1 expired in the emergency room at 6:49 AM.

On 9/20/07 at 12:20 PM, E2 (Director of Nursing) confirmed that there was no documentation in R1's clinical record concerning her abdominal pain on 8/19/07.

The facility's Change of Condition Reporting Policy dated 11/98 states, "To assure the medical care of each guest is supervised by a physician, the nursing staff at the facility shall notify the physician in a timely manner of any significant change in a guest's condition which threatens the health, safety or welfare of the guest. Each wing nurse will be responsible for assessing the guest's condition on a continual basis. The wing nurse will notify the physician and family of any significant change in the guest's condition at the time the change is noted. Changes in a guest's condition will be documented in the progress notes of the chart and on the 24 Hour Daily Log each shift."

The facility's Guest Transfer Policy and Procedure dated 5/2000 states, "Nurse should assess guest's condition for critical status. The nurse will document all activity related to the guest's change of condition and resulting treatments in the Interdisciplinary Progress Notes."

The facility's Pain Management Policy dated 2/06 states, "The guest has the right to expect a rapid and effective response to a complaint of pain. Treat the pain, reassess, and continue to treat the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145891	A. BUILDING ______ B. WING ______	C 09/27/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROSEWOOD CARE CENTER OF ROCKFORD	1660 SOUTH MULFORD ROCKFORD, IL 61108

(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	Continued From page 25	F9999		

pain until the guest is comfortable or side effects prevent further treatment. Notify the physician if pain relief cannot be obtained. Obtain details of the pain's location, duration, and character as they provide valuable clues about how to treat the pain most effectively."

2) R2 is an 89 year old resident with the diagnoses of Congestive Heart Failure, Diabetes Mellitus Type 2, Chronic Renal Failure, Hypothyroid, Anxiety, Hypertension, and Dyspnea, according to the 9/07 Physician Order Sheet (POS).

Review of the resident's Physician Telephone Orders shows that on 9/11/07 at 4:00 PM R2's physician ordered Levaquin for the resident. The order states that the resident is allergic to Levaquin. E13 (LPN) writes, "will contact doctor on 9/12/07." The POS shows that an order was obtained on 9/12/07 at 2:45 PM to discontinue the Levaquin order and to start Z Pack 250mg, 2 tablets the first day and then 1 tablet for 4 days. The Medication Administration Record (MAR) shows that R2 received her 1st antibiotic dose at 8:00 PM on 9/12/07, 28 hours after the 1st antibiotic order.

On 9/20/07 at 2:05 PM E13 (LPN) was asked why she did not contact the doctor for a new antibiotic order on 9/11/07 after finding out the resident was allergic to Levaquin. E13 said, "Well, the doctors are sometimes hard to get a hold of."

On 9/21/07 at 12:30 PM E2 (DON) said that the physicians are available to them 24 hours a day, 7 days a week. E2 was asked if he would have expected E13 (LPN) to contact the doctor for new

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145891	A. BUILDING ______ B. WING ______	C 09/27/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROSEWOOD CARE CENTER OF ROCKFORD	1660 SOUTH MULFORD ROCKFORD, IL 61108

(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	Continued From page 26	F9999		

antibiotic orders on 9/11/07 after discovering the resident was allergic to Levaquin. E2 did not give a response to the question.

Nurse's Notes written by E13 on 9/14/07 at 3:00 PM document that R2 had a temperature of 99.1, respiratory rate of 44 (normal respiratory rate is 18-20 breaths per minute), and her "lungs have wheezes." According to the Physician Telephone Orders Audit form, E13 contacted the Nurse Practitioner, Z1, at 7:00 PM on 9/14/07 and received orders to give R2 Lasix 40mg by mouth (diuretic - one time order) and Xanax 0.25mg (anti-anxiety.) According to the Medication Administration Record (MAR) the resident received the Lasix at 8:00 PM on 9/14/07. The Nurse's notes show that the resident was also given Xanax 0.25mg. The administration of the medication is not on the MAR and the time of the medication administration is not documented in the Nurse's Notes. There is no assessment in the Nurse's Notes documenting the result of the medication. The Nurse's Notes show that the resident was transported to a local hospital for evaluation. The only entry in the Nurse's Notes written by E13 for 9/14/07 is timed at 3:00 PM. The documentation does not indicate the time of transfer. According to the Ambulance report the resident was transported to the hospital at 8:31 PM.

On 9/21/07 at 12:45 PM E16 (Certified Nursing Assistant - CNA) said that on 9/14/07 at 3:30 PM, she first noticed that R2 was having difficulty breathing. E16 said that the resident appeared weak and fatigued, was not talking much (E16 said resident is usually very talkative), and her skin was slightly moist. E16 said that from 3:30 PM to 6:00 PM she had reported at least 6 times

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145891	A. BUILDING ______ B. WING ______	C 09/27/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROSEWOOD CARE CENTER OF ROCKFORD	1660 SOUTH MULFORD ROCKFORD, IL 61108

(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	Continued From page 27	F9999		

to E13 that R2 was having difficulty breathing. E16 said that each time she reported to E13 that R2 was having difficulty breathing; E13 responded that she was aware of the problem. E16 said that at about 6:30 PM she went to E4 (Registered Nurse - RN) and told her about the concerns she had regarding R2's difficulty breathing. E16 said that E4 stopped what she was doing and immediately went to assess R2.

On 9/21/07 at 8:50 AM E4 (RN) said that on 9/14/07 at about 6:30 PM E16 (CNA) came to her and told her that she was concerned about R2's condition. E4 said that E16 had told her that she had reported R2's dyspnea several times to E13. E4 said that E16 said that E13, the nurse caring for the resident, had not assessed her or done anything to help her. E4 said that E16 asked her to go and assess R2. E4 said that when she went into the resident, R2 was "gasping for air." E4 said that she immediately went to get E13 and told her that the resident was very ill and needed to be sent to the hospital immediately.

The facility's Change of Condition Reporting Policy dated 11/98 states, "To assure the medical care of each guest is supervised by a physician, the nursing staff at the facility shall notify the physician in timely manner of any significant change in a guest's condition which threatens the health, safety, or welfare of the guest. Each wing nurse will be responsible for assessing the guest's condition on a continual basis. The wing nurse will notify the physician and family of any significant change in the guest's condition at the time the change is noted. Changes in a guest's condition will be documented in the progress notes of the chart and on the 24 Hour Daily Log each shift."

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145891	A. BUILDING ______ B. WING ______	C 09/27/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROSEWOOD CARE CENTER OF ROCKFORD	1660 SOUTH MULFORD ROCKFORD, IL 61108

(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	Continued From page 28	F9999		

The facility's Guest Transfer Policy and Procedure dated 5/2000 states, "Nurse should assess guest's condition for critical status. The nurse will document all activity related to the guest's change of condition and resulting treatments in the Interdisciplinary Progress Notes".

The Hospital Emergency Department (ED) record of 9/14/07 shows that the resident was triaged at an "Urgency" level. According to the ED record the resident was admitted to a Medical/Surgical Inpatient unit at 12:18 AM on 9/15/07. As of 9/21/07 R2 was still a patient in the hospital.

3) R3 is a 72 year old female resident who was admitted to the facility on 9/9/07 with a diagnosis of a right Total Knee Arthroplasty, according to R3's September 2007 Physician Order Sheet (POS).

Review of the Daily Skilled Nursing Assessment Tool and Narrative Nurse's Progress Notes shows the following:

· 9/9/07 (date of admission) There is no baseline assessment done of R3's surgical site. The Daily Skilled Nursing Assessment Tool states that the wound was not observed this shift. Review of the Nurse's Notes shows that no assessment of the surgical site was conducted.

· 9/10/07 thru 9/12/07 on the 6AM-2PM Shift there is no documentation of the appearance of the surgical wound on the Daily Skilled Nursing Assessment Tool or in the Narrative Nurse's Progress Notes.

On 9/12/07 at 4 PM the Nurse's Notes state,"...Notes redness to right knee. Had

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145891	A. BUILDING ______ B. WING ______	C 09/27/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROSEWOOD CARE CENTER OF ROCKFORD	1660 SOUTH MULFORD ROCKFORD, IL 61108

(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	Continued From page 29	F9999		

dressing to right knee clean, dry, and intact...Guest request plain Tylenol for general and right knee discomfort." The Daily Skilled Nursing Assessment Tool for 9/12/07 on the 2PM-10PM shift under "Site/Describe" states, "Dressing to right knee intact, redness noted around the dressing. "Wound not observed this shift" was circled on the assessment tool.

On 9/13/07 on the 6AM-2PM shift there is no description of the surgical site on either the Daily Skilled Nursing Assessment Tool or in the Nurse's Notes. On the 2PM-10PM shift the Daily Skilled Nursing Assessment Tool states that the dressing to the right knee is clean, dry, and intact and that the wound was not observed this shift. On 9/14/07 at 10:05 Nurses Notes state, "Right leg is swollen, painful, warm to touch, and reddened."

On 9/15/07 at 12:30 PM Nurse's Notes state, "Guest's foot was so swollen, red, tender, she couldn't move it at all." On 9/15/07 (unknown time) R3 was transferred to a local hospital.

The Vital Sign Flow Sheet for R3 shows that R3 had elevated temperatures on 4 of the 7 days that the resident was in the facility. No evidence was found of an assessment conducted or physician notification related to the elevated temperatures.

The Total Knee Replacement Care Plan (no date) for R3 lists as the resident's goal, "Guest will rehabilitate from Total Knee Replacement surgery without complications and obtain optimal mobility status." One of the approaches to the care plan goal is to "Monitor suture line for healing and for signs of infection."

The facility's Documentation Requirements Policy states under procedure that, "Exception and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145891	A. BUILDING ________ B. WING ________	C 09/27/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROSEWOOD CARE CENTER OF ROCKFORD	1660 SOUTH MULFORD ROCKFORD, IL 61108

(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	Continued From page 30	F9999		

change of Condition charting will be completed as necessary. A Daily Skilled Nursing Assessment Tool will be completed on day shift and evening shift each day on all Medicare guests". The Policy also states under Guidelines for Charting, "Record Significant information...Document your observations specifically and objectively...All Nurses Notes should be reflective of the Nursing Care Plan..."

During an interview with E2 (Director of Nursing) on 9/20/07 at 10:30 AM he said that R3 was admitted to the hospital with Cellulitis of the right knee. E2 was unable to provide nursing documentation describing the appearance of the resident's surgical site.

On 9/20/07 at 2:40 PM E15 (Licensed Practical Nurse), said that surgical wounds should be assessed every shift. E15 said that if a resident complains of pain or there is documentation of any problems, the resident should be assessed every shift.

4) R5 is an 86 year old resident whose diagnoses included Congestive Heart Failure, Hypertension, and Compression fractures, according to his September 2007 Physician Order Sheet (POS). The 9/07 POS shows that R5 had a physician order for a 1500cc fluid restriction.

On 9/25/07 E12 and E14 (LPNs) were asked how the staff are made aware of how much fluid a resident on a fluid restriction can have. Both nurses said that the Certified Nursing Assistants (CNAs) ask the nursing staff if a resident may have additional fluid over that given at meal times and at medication pass times. E1 and E14 said

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145891	A. BUILDING ______ B. WING ______	C 09/27/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROSEWOOD CARE CENTER OF ROCKFORD	1660 SOUTH MULFORD ROCKFORD, IL 61108

(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	Continued From page 31	F9999		

that the nurse would check the resident's High Risk Diet Intake sheet to see how much fluid the resident took in during meals in order to determine if the resident may have additional fluid to drink. E14 said that any resident who is on a fluid restriction should have a High Risk Diet Intake.

On 9/25/07 at 12:45 PM E2 (DON) was asked to show the surveyor the meal intake sheets for R5. E2 said that R5 did not have a meal intake sheet because his fluid restriction was monitored due to his cardiac condition not because he had a poor oral intake.

The facility's Intake and Output Monitoring Policy states, "In order to support appropriate fluid balance, promote wound healing, and prevent urinary tract infections, pressure ulcers, or fluid overload, (the facility) will monitor the intake and output of guests who have high risk conditions affecting their fluid requirement or who require a fluid restriction". The policy states that any guest with a fluid restriction order has a high risk condition, requiring intake and output monitoring. The Procedure for the policy includes that the nurse will ensure that a Fluid Intake at Meals form be placed in the Meal Intake Notebook in the dining room to be filled out by the CNAs/Nurse after each meal.

The Fluid Plan for R5 shows that he is offered 900cc of fluid daily from the Dietary Department and an additional 600cc of fluid daily with his medication. Review of the resident's 24 hour intake and output report sheet shows that that the sheet is incomplete. The daily totals of actual fluid intake are not reported. The daily fluid totals show that the resident received less than 1500cc

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145891	A. BUILDING ______ B. WING ______	C 09/27/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROSEWOOD CARE CENTER OF ROCKFORD	1660 SOUTH MULFORD ROCKFORD, IL 61108

(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	Continued From page 32	F9999		

of fluid daily.

The facility Pain Management Policy states, "In order to provide effective pain management for guests experiencing acute or chronic pain, (facility) will follow the basic concepts of pain management including a comprehensive pain assessment on admission, proper administration of pain medication, adjuvant medications and therapies, and ongoing documentation of pain scores when pain is present and/or medication is administered. The guest has the right to expect a rapid and effective response to a complaint of pain. Treat the pain, reassess, and continue to treat the pain until the guest is comfortable or side effects prevent further treatment. Obtain details of the pain's location, duration, and character as they provide valuable clues about how to treat the pain most effectively...".

Review of the facility's Daily Skilled Nursing Assessment Tools for R5 from 9/8/07 through 9/16/07 shows that the resident's pain was not assessed every shift. The pain rating is as follows:
9/8/07 6A-2P no pain rating
2P-10P chronic back pain is documented andrated at a 8-9 out of a 10 pain rating.
9/9/07 6A-2P no pain rating
2P-10P chronic back pain, "severe"
9/10/07 6A-2P no pain rating
2P-10P no pain rating
9/11/07 6A-2P no pain rating
2P-10P chronic back pain, "mod"
9/12/07 6A-2P no pain rating
2P-10P no pain rating
9/13/07 6A-2P pain rated at 7
2P-10P no pain rating, states, "gen disc".
9/14/07 6A-2P pain rated at 7

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F9999	Continued From page 33	F9999		

2P-10P pain rated a 10 out of 10, no location "neck/back"
9/15/07 6A-2P pain rated 10
2P-10P no pain rating, "lower back Pain"

On 9/15/07 (no time) a Pain Assessment sheet was filled out showing that the resident had a significant change regarding his pain. The facility's Change of Condition Policy states, "To assure the medical care of each guest is supervised by a physician, the nursing staff of Rosewood Care Center shall notify the physician in a timely manner of any significant change in a guest's condition which threatens the health, safety, or welfare of the guest."

The Daily Skilled Nursing Assessment Tool has a section in which the nursing staff are to document the skilled resident's urine characteristics. Review of the shift assessments show that the resident's urine characteristics were documented on 9/10/07, 9/12/07 and 9/14/07. The 2P-10P shift for those days reports that the resident has voided quantities sufficient, the color of the urine is clear yellow, there is no odor, and the resident is continent of urine. On 9/15/07 the Daily Skilled Nursing Assessment Tool for the 6A-2P shift documents that the urine is tea color and the 2P-10P Assessment states that the urine is a dark amber in color. The resident's medical record did not show that the resident's pain was assessed and that the physician was notified of the resident's urine color.

Review of the Nurses Notes written by E9 (LPN) for 9/15/07 at 7:00PM shows that the resident was lethargic and slow to respond. E9 documented that the resident "voided a small amount of dark urine, tea colored." On 9/16/07 at

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F9999	Continued From page 34 4:15 AM the resident was found expired. (A)	F9999		