STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6010391	A. BUILDING: _____ B. WING _____	05/28/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROSEWOOD CARE CENTER OF SWANSEA	100 ROSEWOOD VILLAGE DRIVE SWANSEA, IL 62220

(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) COMPLETE DATE
S9999	Final Observations	S9999		

STATEMENT OF LICENSURE VIOLATIONS

300.610a)
300.690c)
300.1210b)
300.3240a)
300.3240b)
300.3240c)
300.3240d)
300.3240e)

Section 300.610 Resident Care Policies

a) The facility shall have written policies and procedures governing all services provided by the facility. The written policies and procedures 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. The policies shall comply with the Act and this Part. The written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, documented by written, signed and dated minutes of the meeting.

Section 300.690 Incidents and Accidents

c) The facility shall, by fax or phone, notify the Regional Office within 24 hours after each reportable incident or accident. If a reportable incident or accident results in the death of a resident, the facility shall, after contacting local law enforcement pursuant to Section 300.695, notify the Regional Office by phone only. For the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6010391	A. BUILDING: _____ B. WING _____	05/28/2014

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ROSEWOOD CARE CENTER OF SWANSEA	100 ROSEWOOD VILLAGE DRIVE SWANSEA, IL 62220

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S9999	Continued From page 1	S9999		

purposes of this Section, "notify the Regional Office by phone only" means talk with a Department representative who confirms over the phone that the requirement to notify the Regional Office by phone has been met. If the facility is unable to contact the Regional Office, it shall notify the Department's toll-free complaint registry hotline. The facility shall send a narrative summary of each reportable accident or incident to the Department within seven days after the occurrence.

Section 300.1210 General Requirements for Nursing and Personal Care

b) The facility shall 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 resident care plan. 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.

Section 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)

c) A facility administrator who becomes aware of abuse or neglect of a resident shall immediately report the matter by telephone and in writing to the resident's representative. (Section 3-610 of

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6010391	A. BUILDING: _____ B. WING _____	05/28/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROSEWOOD CARE CENTER OF SWANSEA	100 ROSEWOOD VILLAGE DRIVE SWANSEA, IL 62220

(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) COMPLETE DATE
S9999	Continued From page 2	S9999		

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)

These requirements were not met as evidenced by:

Based on interview and record review, the Facility failed to develop a written policy to ensure the Administrator is notified immediately of all allegations of abuse, neglect, mistreatment and misappropriation of resident's property. The Facility failed to operationalize its Abuse Policy by not conducting a timely and thorough investigation, allowing a Certified Nurse's Aide (CNA) to have direct contact with residents after incidents of abuse. The Facility failed to operationalize its Abuse Policy by not notifying the Department immediately of allegations of abuse. This has the potential to affect all of the 66 residents living in the facility.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6010391	A. BUILDING: _____ B. WING _____	05/28/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROSEWOOD CARE CENTER OF SWANSEA	100 ROSEWOOD VILLAGE DRIVE SWANSEA, IL 62220

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S9999	Continued From page 3	S9999		

Findings include:

1. On 5/13/13 at 9:45 AM, during the Survey Entrance Interview, E1 stated that he did not have any reportable investigations to be reviewed. He stated no staff, residents or family members had made any abuse allegations in the past year.

2. R34's Physician's Order Sheet (POS) documented a diagnoses in part of; Trans Cerebral Ischemia, End Stage Senile Dementia, and Hypertension. R34's Admission Minimum Data Set 4/2014, documented R34 is severely cognitively impaired, and is a 2 staff assist with all Activities of Daily Living, showers, and transfers.

The Facility's Follow up Report for Alleged Abuse, Neglect and/or Theft, dated 5/21/14, documented the following: On 5/12/14 at 7:30 PM, during R34's shower, E27 Certified Nurses Aide (CNA), was overheard cursing several times at R34 telling him to sit down because he was refusing his shower. E27 took R34 to his bedroom. E28, CNA, witnessed E27 put R34 onto his bed and then roll him over hard.

On 5/21/14 at 12:50 PM, in a phone interview, E1, Administrator, stated although R34's abuse occurred on 5/12/14, it was not reported to him until 5/16/14 between 2:00 PM and 3:00 PM. He was aware staff had not reported it immediately to him and did not know why they did not. E1 stated E27 continued to work on 5/12 and worked an evening shift on 5/15/2014.

E28's Statement, dated 5/16/2014, documented on 5/12/14 at 7:30 PM, E27 was in the shower room and told R34 to "Sit The F***k down several times." E27 told R34 "Oh my F***king God why

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6010391	A. BUILDING: _____ B. WING _____	05/28/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROSEWOOD CARE CENTER OF SWANSEA	100 ROSEWOOD VILLAGE DRIVE SWANSEA, IL 62220

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S9999	Continued From page 4	S9999		

do I always get your shower." E28 documented she helped E27 transfer R34 to bed. E27 rolled R34 onto his side so hard that he almost fell out the other side of the bed. E28 documented that she left the room to get E29, Licensed Practical Nurse (LPN). E28 told E29 what had happened to R34 then left the area. E28 documented a few days later she also told E30, Registered Nurse (RN), what had happened to R34.

In an interview with E28 on 5/21/14 at 8:15 PM, she confirmed the above statements. E28 stated she helped E27 put R34 onto the side of his bed, but then went to help R34's roommate. E28 stated once E27 had R34 laid down on the bed, E27 rolled R34 over onto his side so hard he almost fell off the side of the bed. E28 stated E27 had to grab him and pull him back. E28 stated she thought when she told E29 what had happened, E29 would intervene and take care of R34, but E29 did nothing. E28 stated when she came back to work on 5/16/14 she sought out E30 and told her. E30 said she would tell E1.

E29's Statement, dated 5/16/14, documented that on the evening of 5/12/14, E28 told her that E27 had rolled R34 so hard in his bed that he almost fell on the floor. E29 documented "I did not think this held any merit because these two CNA's have been sniping and sniping at each other for the better part of three weeks. R34 can be resistive to care and can at times be combative. He requires 2 people to take care of him."

On 5/21/14 at 8:15 PM, E29 stated "I was not told that(E27) had been cursing at (R34). (E28) did say that (E27) had rolled (R34) too hard when putting him to bed. (E27) and (E28) were upset and arguing with each other about who was supposed to help who with resident care. It is

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6010391	A. BUILDING: _____ B. WING _____	05/28/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROSEWOOD CARE CENTER OF SWANSEA	100 ROSEWOOD VILLAGE DRIVE SWANSEA, IL 62220

(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) COMPLETE DATE
S9999	Continued From page 5	S9999		

common knowledge that these two girls argue. (E28) did not say anything about (E27) cursing at (R34) in the shower. I did go and look at (R34) that evening after he was in bed and he seemed fine. I did not think anything happened to (R34) that should be reported as abuse or otherwise."

E30's Statement, dated 5/16/14, documented: "On 5/15/14, (E28) came to me at about 5:30 PM and asked to talk to me. She said that on a evening that I was not working, another CNA (E27) was overly rough with (R34) and was cursing at him and nearly rolled him out of the bed. (E28) said she told the other nurses that night but nothing happened."

On 5/21/14, at 7:50 PM, E30 stated "I did not work on 5/12/14. On the evening of 5/15/14, (E28) told me about the event with (E27) and (R34). I am a new nurse here, and I knew this had to be reported, but there was no one from the office here at the time, and so I reported it the next day, 5/16/14 to E3, Assistant Director of Nursing (ADON) and E1.

3. On 5/13/14, at 1:45 PM, R6 stated that one day near the end of April, he was leaving Physical Therapy, and a staff member came up to him and kissed him on both cheeks and his forehead. After kissing him, the staff then stated "I really, really love you." The staff was in street clothes, and was a lady. R6 stated he was shocked by this behavior, and although he could not remember the staff face or name, he felt very uncomfortable being touched in this manner. R6 stated he told Z4, his wife, about this incident, and Z4 had spoken to E1 but no one from the facility had talked to him about this event. R6

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6010391	A. BUILDING: _____ B. WING _____	05/28/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROSEWOOD CARE CENTER OF SWANSEA	100 ROSEWOOD VILLAGE DRIVE SWANSEA, IL 62220

(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) COMPLETE DATE
S9999	Continued From page 6	S9999		

stated repeatedly that this event made him uncomfortable even to speak of it now.

On 5/14/14 at 11:15 AM, E1 stated "Around 5/2/14, (Z4) did come and tell me that a staff member had kissed (R6) and told him she loved him. (Z4) was not happy about this incident and said it had made (R6) uncomfortable. I went to the Physical Therapy Dept and asked 3 or 4 staff there if they had seen or witnessed this event. They all said they had not seen anyone kissing (R6) at any time. Because I could not find anyone that had witnessed (R6) being kissed, and figured (R6) just made the story up. I did not talk or interview (R6) about the event. I did not do an incident report, write down any of this information, or send anything to the Department. I didn't see what the need to report this event as I did not think it was abuse. I couldn't verify anything had happened, and there was nothing to document."

On 5/15/14, in an interview with E2, Director of Nursing (DON), she stated she was not in the building at the time of this event, but had heard about it. E2 stated E1 is the Facility Abuse Coordinator and handles these types of complaints. E2 stated at this time there is only one female resident in the building who wanders, and she would not kiss anyone as she is more withdrawn and does not readily approach other residents. E2 stated that R6 was an alert resident, and she had not heard of him making up stories about staff in the past.

4. A review of the Facility Follow up Report for Alleged Abuse, Neglect and/or Theft dated 12/30/13 documented "R28 was missing two rings. R28 was seen wearing the rings on 12/26/13, but on 12/27/13 the rings were reported

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6010391	A. BUILDING: _____ B. WING _____	05/28/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROSEWOOD CARE CENTER OF SWANSEA	100 ROSEWOOD VILLAGE DRIVE SWANSEA, IL 62220

(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) COMPLETE DATE
S9999	Continued From page 7 missing by a family member. The search continues." On 5/16/14 at 11:00 AM, E1 stated "At the time R28's gold rings went missing, he was on hospice and dying. Several family members had been coming in and out to see R28 over the holiday. R28's family told the staff on 12/27/13 about the missing rings. No one told E1 of the problem until 12/30/13. E1 stated he did call the police and they did file a report. E1 stated he is aware that this event should have been reported immediately. E1 stated he does not know why staff failed to report this to him sooner, but thinks because it was a holiday weekend, they waited until the following Monday. E1 stated he did report it to the department, but it was 3 days later on 12/30/13. 6. The Facility's Preliminary 24-hour Abuse Investigation Report, dated 6/26/13, at 4:40 PM documented: E33 and E34, Certified Nurses Aides, reported E35, CNA was over heard talking to R29 during personal care, about the size of his penis. R29 was interviewed and did not recall this happening. This event happened on 6/19/13, and was reported on 6/25/13 at 5:00 PM toE1. E33's Statement, dated 6/26/13, documented that E35 told R29 "I know why you don't want me to see you, it's because your penis is small." On 5/16/14 at 11:15 AM, E1 stated "On 6/19/13, E33 and E34 did hear E35 tell R29 he had a small penis while giving him personal care. I know it was 5 days before staff informed me of this event, and I don't know why they didn't tell me immediately. That staff member was terminated.	S9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6010391	A. BUILDING: _____ B. WING _____	05/28/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROSEWOOD CARE CENTER OF SWANSEA	100 ROSEWOOD VILLAGE DRIVE SWANSEA, IL 62220

(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) COMPLETE DATE
S9999	Continued From page 8	S9999		

I did notify the Department although it was 7 days later, but I wasn't told until then."

7. On 5/16/2014, at 9:30 AM, R17 was interviewed related to her care at the Facility. R17 reported she had been a resident at the Facility for over 3 years. When asked if anyone at the Facilty had taken any of her belongings without permission, R17 stated, "I had $7.00 stolen from me. I went to (E1), Administrator and he gave me the money back. I think it might be a housekeeper (E5). I came in and found her sitting in my room reading my magazine. I asked her what she was doing in my room and (E5) told me she was reading." R17 reported she has a stuffed animal collection and has had several of the toys stolen from her room. R17 stated, "I keep count of them now. I currently have 37. I keep all of my money with me in my wheelchair or under my pillow when I'm in bed." R17 was alert and oriented to all spheres, and reported she is the Facility's Resident Council President. R17 reported the incident happened several months ago.

On 5/16/2014 at 10:00 AM, as R17 was in the hall by the 300/400 hall nurses station, R17 pointed to E5, who was cleaning on the 400 hall at that time. R17 reported she has seen E5 cleaning on the 300 hall where she resides, but no longer cleans her room. R17 reported she did not trust E5 and had talked to E6, Housekeeping Supervisor about this issue.

On 5/16/2014, at 10:15 AM, E1, Administrator was interviewed related to R17's complaints of missing money. E1 reported R17 reported the missing $7.00 eight or nine months ago,and he

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6010391	A. BUILDING: _____ B. WING _____	05/28/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROSEWOOD CARE CENTER OF SWANSEA	100 ROSEWOOD VILLAGE DRIVE SWANSEA, IL 62220

(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) COMPLETE DATE
S9999	Continued From page 9	S9999		

replaced it. E1 reported he did not investigate the alleged theft of the money. E1 stated, "I just gave her the money back, and told her I will keep her money for her so this won't happen again." When asked if he was aware R17 suspected E5 and had reported this to E6, E1 stated, "No. I'll talk to (E6) about his."

On 5/16/2014, at 12:45 PM, E6 was interviewed about R17's missing money and finding E5 in her room reading her magazine. E6 stated, "We do not let that housekeeper (E5) clean her (R17) room anymore. I observe (E5) closer. E5 told me she was no longer looking at magazines. There was no suspension, just a verbal warning." When asked if R17 had reported missing a few of the stuffed animals to her, E6 stated, "Yes. (R17) had told me. It was around the time the money was missing. I didn't know who did it or what they were. I did report it to E1, and I don't know what was done about it. I searched the rooms for the (stuffed animals), and none were found. E5 does work on R17's hall, but I will speak to E1 about it, and she won't work that hall anymore." E6 reported she did not complete a incident report or a witness statement related to the incident.

8. A review of the Facility Abuse Investigation Policy, Rev 05-2013, documented:
Policy - Any employee alleged to the Abuse Prevention Coordinator to have perpetrated Resident abuse will be immediately barred from further contact with all Residents until the matter is properly resolved. The Abuse Prevention Coordinator will render a decision regarding the validity of the allegation based on analytical judgement. All allegations of abuse will be reported in a timely manner to the State Agency in accordance with current regulations.
2. Timely Reporting - Abuse allegations must be

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6010391	A. BUILDING: _____ B. WING _____	05/28/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROSEWOOD CARE CENTER OF SWANSEA	100 ROSEWOOD VILLAGE DRIVE SWANSEA, IL 62220

(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) COMPLETE DATE
S9999	Continued From page 10	S9999		

initially reported by the Administrator to the State Agency within 24 hours of occurrence except in cases of serious bodily injury resulting from a suspected crime.
Procedure - 1. Employee as Perpetrator of Abuse: When an investigation of a report of suspected abuse of a resident indicates, based on credible evidence, that an employee of a long-term care facility is the perpetrator of the abuse, that employee shall be barred from further contact.....
#4 - Upon receipt of the Notification of Suspected or Witnessed Abuse, the Abuse Prevention Coordinator or Designee will notify the Resident or Resident's representative of the alleged incident and of the progress of the investigation by telephone and/or in writing unless otherwise provided by law.
#6. The Abuse Prevention Coordinator will notify the Illinois Department of Public Health via facsimile, or telephone on holidays or weekends, of the alleged abuse incident within 24 hours of the receipt of the allegation, unless serious bodily injury is present... a 2 hour time limit for reporting must be followed.
Page 5 - If You See Abuse, You Must Report It: Any employee who has actual knowledge of the abuse of neglect of a resident shall immediately submit a complaint to the Abuse Prevention Coordinator.

9. The Resident Census and Conditions of Residents, CMS 672 dated 5/14/14, documents that the facility has 66 residents living in the facility.

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6010391	A. BUILDING: _____ B. WING _____	05/28/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROSEWOOD CARE CENTER OF SWANSEA	100 ROSEWOOD VILLAGE DRIVE SWANSEA, IL 62220

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ROSEWOOD CARE CENTER OF SWANSEA
PLAN OF CORRECTION SURVEY DATE: 5/28/14

The facility has ensured and will continue to insure that residents are free from verbal, mental, physical, or sexual abuse. All facility staff will be reinserviced on facility policy regarding abuse. This will include reporting any incident of potential abuse at the time that potential abuse occurs. This will include reporting any verbal abuse involving swearing at residents and potential rough treatment of residents in a timely manner. The inservice will also include reporting any incident to the abuse prevention coordinator or designee so the incident can be reported and investigated. The facility administrator and consultant m will review all reported accident/incident reports or incidents of potential abuse to insure timely reporting and investigation of any potential abuse. If deficiencies are noted staff will be counseled or disciplined. Completion Date: 6/1/14

The facility has an abuse policy that requires reporting of abuse to the facility abuse coordinator in accordance with state and federal guidelines and requires the abuse coordinator to thoroughly and timely investigate the allegation of abuse. The facility policy also requires the facility to report the allegations to the IDPH in a timely manner in accordance with state and federal guidelines. All facility staff will be reinserviced on facility policy regarding abuse. This will include reporting an incident of potential abuse at the time that potential abuse occurs. This will include reporting any verbal abuse involving swearing at residents and potential rough treatment of residents in a timely manner. The inservice will also include reporting any incident to the abuse prevention coordinator or designee so the incident can be reported and investigated in a timely manner. The facility administrator and consultants will review all reported accident/incident reports or incidents of potential abuse to insure timely reporting and investigation of any potential abuse. If deficiencies are noted staff will be counseled or disciplined. Completion Date: 6/1/14

The facility has developed and implemented written policies and procedures that prohibit mistreatment, neglect, and abuse of residents. This includes operationalizing the policy by inservicing staff on the policy at least once a year and orienting new hires to the policy prior to working with residents at the facility. All facility staff will be reinserviced on facility policy regarding abuse. This will include reporting an incident of potential abuse at the time that potential abuse occurs. This will include reporting any verbal abuse involving swearing at residents any potential rough treatment of residents in a timely manner. The inservice will also include reporting any incident to the abuse prevention coordinator or designee so the incident can be reported and investigated in a timely manner. The facility administrator and consultants staff will review all reported accident/incident reports or incidents of potential abuse to insure timely reporting and investigation of any potential abuse. If deficiencies are noted staff will be counseled or disciplined. Completion Date: 6/1/14