STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145694	A. BUILDING ______ B. WING ______	C 02/04/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROSEWOOD CARE CENTER OF JOLIET	**3401 HENNEPIN DRIVE JOLIET, IL 60435**

(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 309	Continued From page 2 in a timely matter. Under number seven the Director of Nursing is to assess each guest's change of condition daily, review the 24 hour daily log, interview staff and monitor the clinical documentation. The facility did not provide any such documentation. The facility policy, titled Infection Control-C-Diff (Clostridium Difficile Infection), dated May 2011, documents on the first page that resident's with C-Diff will have the physician contacted to discontinue the use of anti-diarrheal's. On 1/9/13 at 9:50 AM E8 Registered Nurse stated, " If I did not agree with the physician orders I would call my Director of Nurse's ". On the same date at 9:50 AM E9 Registered Nurse stated, " If I am not sure of the order I get from the Doctor I would call the Director of Nurse's ". On 1/9/13 at 12:00 PM E4 Certified Nursing Assistant stated, " R3 took herself to the bathroom. I never really looked at what was in the toilet because she would flush it before I got in there. I would just ask if she had a bowel movement and she would say yes or no. I do remember that she had clostridium difficile. I do not recall her having diarrhea. " On 1/9/13 at 12:15 PM E3, Registered Nurse stated per phone interview, "I do not recall R3. I would not have tried to get an order for Imodium for a resident that has Clostridium Difficile. If I did not agree with the physician order I would have called my Director of Nursing " .	F 309		
F9999	FINAL OBSERVATIONS LICENSURE VIOLATIONS 300.610a) 300.1210b) 300.1210d)3)	F9999		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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F9999	Continued From page 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 written, signed and dated minutes of such a meeting. 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. d) Pursuant to subsection (a), 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	F9999		

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F9999	Continued From page 4 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. (Section 2-107 of the Act) THESE REQUIREMENTS WERE NOT MET AS EVIDENCED BY: Based on Interview and Record Review the facility failed to monitor and assess a resident with bloody stools. The facility failed to notify the Director of Nursing after there was a change in the resident's condition. The facility failed to follow the policy for residents regarding change of Condition and Infection Control-Clostridium Difficile Infection. These failures contributed to R3's delay in treatment from 10/13/12 to 10/14/12 when R3 expired due to a massive colonic hemorrhage. This applies to 1 of 4 residents reviewed for improper nursing care, assessment, and monitoring after a Change of Condition in the sample of four. The Findings include: R3 was a 69 year old resident with a history of Clostridium Difficile starting on 10/3/12. R3 was admitted to the facility on 9/19/12 status post surgical debridement of left foot. On 10/3/12 at 10:00 AM, R3 ' s nursing note documented that R3 reported having four loose	F9999		

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F9999	Continued From page 5 stools. E3, Registered Nurse notified the physician. Order to culture the stool for C-Diff (Clostridium Difficile) was received. On 10/6/12 per nursing note R3's stool culture came back positive for C-Diff and was placed on Contact Isolation per physician order. On 10/11/12 E7, Registered Nurse documented, "Received a call from physician ...order received for Imodium (anti-diarrheal). " On 10/13/12 at 7:55am E3 documented, "Writer noted a small amount of bright red blood in the toilet and toilet paper. Guest (R3) also has an external hemorrhoid ". Z1 physician for R3 was notified. Z1 gave an order, " notify MD if stool is black. " At 1:30pm the same day it is documented in the nursing notes that R3 had no further bowel movements. There is no documentation of abdominal assessment, or vital signs after the bloody stool was first observed. There is no further documentation in the nursing notes until 10/14/12 at 7 AM. E5 Registered Nurse documents at 5:45 AM R3 " had a bloody stool." At 5:47 AM this same note documented R3 was "shaking and having breathing trouble." E5 called 911 and put R3 in bed. A Non-Rebreather mask with oxygen was placed on R3 by E5. At 5:58 AM, " Paramedics arrived, R3 was no longer breathing. " At 6:10 AM the community paramedics pronounced R3 deceased. There is no documentation provided by the facility or in R3's clinical record to show the Director of Nursing was notified of the change of condition for R3. The Change of Condition Policy dated 8/98, provided by the facility, under number three guides the nurse to, " ... All such condition changes will be reported to the director of nursing in a timely matter. Under number seven the	F9999		

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F9999	Continued From page 6	F9999		

Director of Nursing is to assess each guest's change of condition daily, review the 24 hour daily log, interview staff and monitor the clinical documentation. The facility did not provide any such documentation.
The facility policy, titled Infection Control-C-Diff (Clostridium Difficile Infection), dated May 2011, documents on the first page that resident's with C-Diff will have the physician contacted to discontinue the use of anti-diarrheal's.
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(B)