STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145647	A. BUILDING _____ B. WING _____	C 02/03/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROSEWOOD CARE CENTER OF PEORIA	1500 WEST NORTHMOOR ROAD PEORIA, 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 000	INITIAL COMMENTS Complaints #1123899/IL55664--No Deficiencies #1220272/IL56106--No Deficiencies #1220406/IL56280--F323	F 000		
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to ensure that safety devices are in place for one of three residents (R3) reviewed for falls in the sample of 10 residents. As a result of this failure, the resident sustained a laceration to the left orbit/temporal area, a skin tear to the left knee,and left hip pain requiring an emergency department visit. Findings include: Care plan for R3, dated 11-7-11, documents an identified problem area of "At Risk for Falls" with the following intervention: "7/19/11 bed alarm to alert staff of attempts to transfer without assist." Care plan also documents that R3 had an identified problem area of "Cognitive skills for daily decision making moderately impaired--decisions poor; cues/supervision	F 323		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 323	Continued From page 1 required related to dementia." On 2-1-12 at 1:30 PM, E3/CNA (Certified Nursing Assistant) stated that E3 was the staff member who found R3 lying next to the bed on 1-23-12 and that there was no alarm sounding at the time. E3 stated that R3 did not have a bed alarm on the bed as she usually did. ED (emergency department) Encounter Form documents that R3 had a 2 cm (centimeter) laceration, swelling and ecchymosis (bruising) to the left orbit/temporal, left hip pain, and 6 cm skin tear to the left knee as the result of "GLF (ground level fall) from bed to ground."	F 323		