STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145411	A. Building B. Wing	10/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Rose Garden of Pana	900 South Chestnut Pana, IL 62557

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44556 Based on observation, interview, and record review, the facility failed protect residents' private space from wandering residents for 5 out of 5 residents (R11, R12, R14, R36, and R45) reviewed for resident rights in a sample of 27. Findings include: On 10/28/24 at 1:43 PM, R48 was observed wandering up and down the 100 hallway with no staff supervision. On 10/28/24 at 1:46 PM, R48 was observed wandering on the 100 hallway and was observed going into one of the rooms on the hall. He remained in room for several minutes with no staff attempting to find or check on him. On 10/28/24 at 2:00 PM, R48 was observed wandering back out on the 100 hallway. On 10/28/24 at time unknown R48 attempted to get out the smoker's door. You must have a code to get in and out of the door and it is not a fenced in courtyard. On 10/28/24 at 3:25 PM, R48 was observed wandering down the 400 hallway. On 10/28/24 at 3:56 PM, R48 was observed still wandering the facility. He was observed touching the smoker's door which is located on the 200 hallway. On 10/30/24 at 08:02 AM, R48 was observed ambulating down the hallway unattended and then attempting to open dietary door on 400 hallway. 1. R11's Face Sheet, with a print date of 10/30/24, documented R11 has diagnoses of but not limited to Diastolic congestive heart failure (CHF), acute and chronic respiratory failure with hypoxia, muscle weakness, and other abnormalities with gait and mobility. R11's Minimum Data Set (MDS), dated [DATE], documented R11 is cognitively intact with a Brief Interview for Mental Status (BIMS) of 15 out of 15 and she is independent with all her activities of daily living (ADLs). (continued on next page)

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 10/30/24 at 12:46 PM, R11 stated R48 wanders up and down the hallways all the time. R11 said one night she woke up at around 12:30 AM to go to the bathroom and as she was standing up, she just happened to look down and seen two feet. She said she knew they were R48's feet that were standing there and it kind of scared her. She said one time he even walked in on her while she was using the bathroom. V11 said she told one of the nurses that if R48 were to hit her it would be over for her due to her being so weak and unsteady on her feet. 2. R36's Face Sheet, print date of 10/30/24, documented R36 has diagnoses of but not limited to unspecified dementia, unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety, hypertension (HTN), major depressive disorder, and anxiety disorder. R36's MDS, dated [DATE], documented R36 is cognitively intact with a BIMS of 14 out of 15 and is independent with most of his ADLs. On 10/30/24 at 1:40 PM, R36 stated R48 came into his room one time and R48 told him to get out because this was his room. There was also a time he came down and was pounding on the door and yelling. R36 said when he sees him wandering down his hallway he will get up and shut the door. On 10/29/24 at 11:15 AM, during resident council, R36 stated R48 came into his bedroom claiming it was his even though R36 told him it was not. R36 stated he had to call staff in to remove R48 but can't remember when this happened. R36 stated R48 wandered up to his dining table and took his tea one time also. 3. On 10/29/24 at 11:13 AM, during resident council, R14 stated about a month ago, R48 came into her room, sat on the spare bed, and started to take off his shoes. R14 stated she told R48 to stop, he was in the wrong place, but he proceeded to take off his shirt. R14 stated she then had to press her call light to get staff to help get him out of her room. 4. On 10/29/24 at 11:18 AM, during resident council, R12 stated R48 has wandered into her room, and she feels like his wandering is getting worse. R12 stated R48 tries to take other resident's food and drinks; he tried taking her water one day. R12 stated R48 doesn't listen to staff even if they are there. R12 continued stating R48 continues to do whatever he wants, there isn't anyone here that is able to take care of him and his sister tries to intervene because she is also a resident here. 5. On 10/29/24 at 2:05 PM, the facility's resident council meeting minutes for the past three months were reviewed and documented on 07/17/24 residents feel uncomfortable with another resident entering their rooms. On 10/29/24 at 2:10 PM, the facility's grievances for the past three months were reviewed and documented on 07/04/24 and 07/07/24 around 7:00 PM another male resident came into his room and would not leave even though R45 asked him to several times. This other resident approached R45 and acted as though he was going to hit R45. R45 stated he drew his fist up and was going to hit this other resident if he hit him. A CNA came into the room and redirected this other resident out. 6. R48's Face Sheet, with a print date of 10/30/24, documented R48 has diagnoses of but not limited to unspecified, dementia, mild, with agitation, chronic obstructive pulmonary disease (COPD), Depression, and anxiety disorder. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R48's BIMS is 99- severely cognitively impaired. R48's MDS, dated [DATE], documented R48 is severely cognitively impaired and requires supervision/touching assistance with eating, partial/moderate assistance with sitting to lying, lying to sitting. sitting to standing, transfer, substantial/maximal assistance with oral hygiene, upper body dressing, dependent with toileting hygiene lower body dressing, putting on/taking off footwear, personal hygiene, rolling left/right, and he is always incontinent of bowel and bladder. R48's Care Plan, with an admitted [DATE], documented R48 is/has the potential to be physically aggressive related to (r/t) dementia. Interventions include but are not limited to 15-minute checks in common areas and analyze times of day, places, circumstances, triggers, and what de-escalates behavior and document. It also documents R48 is/has the potential to be verbally aggressive r/t dementia. Interventions include but are not limited to Analyze of key times, places, circumstances, triggers, and what de-escalates behavior and document, assess, and anticipate resident's needs: food, thirst. toileting needs, comfort level, body positioning, pain etc., monitor behaviors every shift. Document observed behavior and attempted interventions, and when the resident becomes agitated: Intervene before agitation escalates; Guide away from source of distress; Engage calmly in conversation; If response is aggressive, staff to walk calmly away, and approach later. On 10/30/24 at 9:04 AM, V17 (R48's wife) was contacted at this time. She said when R48 was admitted to the facility he was back on the locked unit and he went crazy. She said there wasn't enough room for him to walk and he likes to walk a lot, so they moved him out onto the other hall. V17 said she has suggested they try putting him back on the unit for a few hours a day and then work up to more hours until he is able to stay back there but the facility said they didn't want to be responsible for him hitting anyone because the last time he was back there he did hit someone and urinated on some lady's locker or something. V17 stated R48 should be a 1:1 but they have only made him a 1:1 for a week or two at a time then taken him off. She said the only reason he was a 1:1 yesterday (10/29/24) was because the state surveying agency was in the building, and they made him one after they found him in the therapy room that morning on the floor. She said there has been time they didn't know where R48 was at, and she said one night at 9:00 PM they found him in the kitchen by himself. On 10/31/24 at 1:40 PM, V1 (Administrator) stated she would expect the staff to try and redirect the resident from wandering into another resident's room. She said they will sometimes place the resident 1:1 with activities or even social service if they don't have enough staff to do it. She said they try to give R48 1:1 attention and try to redirect him elsewhere. She said they have had R48 on 1:1 the last couple of days due to medication changes being done. V1 said R48 will get focused on one room, and they will have to put a stop sign across the door. On 10/31/24 at 9:57 AM, V1 (Administrator) and V5 (MDS Coordinator) both stated the facility doesn't have a policy regarding resident rights.

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F 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49494 Based on interview and record review the facility failed to provide Medicare written notice regarding the right to an expedited review of a service termination (Notice of Medicare Non-Coverage/NOMNC) and/or the written notice of the resident's potential liability for a non-covered stay (Skilled Nursing Facility Advance Beneficiary Notice/SNF ABN) for 2 of 3 residents (R17 and R44) reviewed for Beneficiary Protection Notification in the sample of 17. Findings include: 1. R17's EMR (Electronic Medical Record) documented that R17 was originally admitted to the facility on [DATE]. R17's EMR documented R17 was admitted to a local hospital on 2/8/24 with a diagnosis of CHF (congestive heart failure). R17's EMR documented R17 was readmitted to the facility on [DATE] on Medicare Part A for skilled services. R17's EMR documented R17's last day of Medicare Part A coverage was 4/24/24. A review of R17's CMS-10055 Skilled Nursing Facility Advance Beneficiary Notice (SNF ABN) revealed that R17 was given and signed the SNFABN on 4/24/24 and that R17 was not given at least 2 days' notice of his Medicare Part A coverage ending. 2. R44's EMR documented R44 was originally admitted to the facility on [DATE]. R44's EMR documented that R44 was admitted to a local hospital on 7/5/24 with diagnoses of pneumonia and dehydration. R44's EMR documented that R44 was readmitted to the facility on [DATE] on Medicare Part A for skilled services. The surveyor requested R44's CMS-10055 Skilled Nursing Facility Advance Beneficiary Notice (SNF ABN) and the facility was unable to provide a NOMNC for R44's Medicare A coverage that ended on 9/16/24. On 10/30/24 at 12:48 PM V25 (Regional Director) stated that she would expect the residents to be given at least two days' notice before the end of Medicare Part A coverage. On 10/30/24 at 12:50 PM V24 (Social Service Director) stated that she mailed a SNFABN to R44's family but does not have any evidence that this was mailed and received. On 10/31/24 at 10:40 AM V1 (Administrator) stated that the facility does not have a policy for beneficiary notification.

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44556 Based on interview and record review the facility failed to ensure residents were free from physical abuse for 3 of 3 residents (R11, R37, and R48) reviewed for abuse in a sample of 27. Findings include: 1. R11's Face Sheet, with a print date of 10/30/24, documented R11 has diagnoses of but not limited to Diastolic congestive heart failure (CHF), acute and chronic respiratory failure with hypoxia, muscle weakness, and other abnormalities with gait and mobility. R11's Minimum Data Set (MDS), dated [DATE], documented R11 is cognitively intact with a Brief Interview for Mental Status (BIMS) of 15 out of 15 and she is independent with all her activities of daily living (ADLs). R11's Progress Note, dated 10/19/2024 at 5:20 PM, documented Resident informed staff that she was sitting on the seat of her walker when another resident came up to her and started a conversation. Resident states she was talking to them when they got behind her and attempted to push her walker. Resident stated she told the other resident to stop pushing on her walker, states her feet were on the floor & stopping them from moving her. Resident states that the other resident became upset with her and struck her in the middle of her back with his hand. Incident was not witnessed by staff. Staff assessed resident, no discoloration or swelling noted to resident's back. Other resident was re-directed by staff with success. Will continue to monitor. R11's Progress Note, dated 10/20/2024 at 2:49 PM, documented R11 voiced her concern regarding the other resident entering her room. On 10/30/24 at 10:48 AM, R11's Illinois Department of Public Health (IDPH) final report was reviewed and documented an incident that took place between R11 and R48 in the main lobby of the facility on 10/19/24 at 6:45 PM. It documented R11 was cognitively intact with a BIMS of 15 out of 15 and R48's BIMS was 99-severely cognitively impaired. On October 19th, at approximately 5:30 PM 2024, a resident-to-resident altercation happened in the front lobby. According to R11, R48 approached her when she was sitting on the seat of her walker. R48 attempted to push her walker and she told him not to do so. R11 states he then struck her back with his hand. R48 was successfully redirected by staff. Nursing assessment indicted no injury to either resident. R48 was placed on 1:1 observation in common areas for 72 hours. Administrator, PCP, and POA notified of incident. The Interdisciplinary Team (IDT) determined that this event likely occurred to resident R48's, diagnosis of dementia. R48 was recently diagnosed with late stages of dementia and placed on hospice effective Friday, October 18th, 2024. R48's recent U/A (urinalysis) results received on October 19th, 2024; no culture was indicated. Local hospice completed a medication review. New orders received to change Ativan 0.5 MG every 4 hours routinely, in addition to Ativan 0.5 MG every 2 hours PRN. IDT will continue to monitor effectiveness and update care plan as needed. In addition to working close with primary care physician and hospice provider. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/30/24 at 12:46 PM, R11 stated R48 wanders up and down the hallways all the time. She said she had an incident that involved R48 a couple of weeks ago. She said she was up front with her walker, and she was sitting down on it. She said she like to go up there after supper just to get out of her room. R11 said R48 came up behind her and grabbed the back of her walker and she told him not to do that. She said R48 then let go of her walker, came around the right side of her walker, and hit her in the right shoulder. R11 said it doesn't hurt now but it did for about two hours after it happened. R11 said she has never feared R48 until he hit her and now R48 scares her. V11 said she told one of the nurses that if R48 were to hit her it would be over for her due to her being so weak and unsteady on her feet. 2. R48's Face Sheet, with a print date of 10/30/24, documented R48 has diagnoses of but not limited to unspecified, dementia, mild, with agitation, chronic obstructive pulmonary disease (COPD), Depression, and anxiety disorder. R48's MDS, dated [DATE], documented R48 is severely cognitively impaired and requires supervision/touching assistance with eating, partial/moderate assistance with sitting to lying, lying to sitting. sitting to standing, transfer, substantial/maximal assistance with oral hygiene, upper body dressing, dependent with toileting hygiene lower body dressing, putting on/taking off footwear, personal hygiene, rolling left/right, and he is always incontinent of bowel and bladder. R48's Care Plan, with an admitted [DATE], documented R48 is/has the potential to be physically aggressive related to (r/t) dementia. Interventions include but are not limited to 15-minute checks in common areas and analyze times of day, places, circumstances, triggers, and what de-escalates behavior and document. It also documents R48 is/has the potential to be verbally aggressive r/t dementia. Interventions include but are not limited to Analyze of key times, places, circumstances, triggers, and what de-escalates behavior and document, assess, and anticipate resident's needs: food, thirst. toileting needs, comfort level, body positioning, pain etc, monitor behaviors every shift. Document observed behavior and attempted interventions, and when the resident becomes agitated: Intervene before agitation escalates; Guide away from source of distress; Engage calmly in conversation; If response is aggressive, staff to walk calmly away, and approach later. On 10/29/24 at 2:09 PM, Illinois Department of Public Health (IDPH) final report was reviewed and documented an incident that took place between R36 and R48 on 08/11/24 at 3:45 PM on the 100 hallway. It documented R48's BIMS was 99- severely cognitively impaired and R36's BIMS was 14 out of 15. On August 11th, 2024, at approximately 3:45 PM, resident to resident altercation. R36 and R48 were at nurse's station. While R36 was obtaining water from staff, R48 approached a cart that was nearby containing gardening supplies. R48 was asked to step away from the gardening cart. R48 began verbally arguing back and turned away from the cart, ending up close to R36. R36 stated to R48 get out of the way. Both residents started arguing back and forth with each other at this time. Before the nurse could get around the nurses' station to the residents, R36 pushed R48 with his hip. R48 in turn, grabbed him (R36) and R36 hit R48 in the head with his fist. When the nurse made her way around the nurses' station R36 had both arms around R48 and stated, I'm trying to make sure he doesn't fall. R48's left hearing aid was disheveled. R36 then released R48, and nurse immediately separated residents from each other. Nursing assessment indicated a skin tear to R 38's right hand. Nurse notified V1, administrator, V20, PCP, and POA's of incident. Residents were both placed on 15-minute checks with visuals in common areas. R38's wife (V17) came into facility to sit with him for the evening. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facilty's incident statements documented V21, Licensed Practical Nurse (LPN): R36 and R48 were at nurses' station. R36 was getting water from staff. R48 was wondering when he approached a cart R36 had nearby containing gardening supplies. R48 began to reach into a box on the cart, he was asked to stop by another resident. R48 began verbally arguing with that resident, then turned away and was standing very close to R36. R36 stated get out of the way. R48 responded in an aggressive tone. From where I was at the nurse's desk, I cannot confidently state which resident-initiated contact, but I did see R36's arm near the back of R48's head. Both residents were yelling at each other. When I made my way around the nurses' station to the residents, R36 had both arms around R48 and stated, I'm trying to make sure he doesn't fall. R48's left hearing aid was disheveled. R36 released R48 and R48 was removed from the immediate area. I then removed myself and contacted Admin, MD, and POA's. Other staff remained with both residents. The facility's incident statement documented V22, Certified Nursing Assistant (CNA): R36 was at the nurses' station waiting to go out to water the flowers and R48 came up to him (R36) and R36 said 'get out of my way. R48 didn't move so R36 pushed R48 with his hip. R48 grabbed R36 and R36 hit R48 in the head with his fist. The IDT determined that this event likely occurred due to resident diagnosis of dementia. R48 has a disorganized thought process and is easily over stimulated. He wanders throughout the facility all day and he is impulsive and with poor safety awareness. V20 informed no new orders for either resident but requested phone conference with facility administrator for 8/12/24. A message left for V23, Psychiatric Physician, was also placed. Consults requesting return call with estimated date of next facility visit. R48 remains on 15-minute checks and visuals in common areas at this time. In addition, a medication review was ordered for R36, and resident remained on 15-minute checks for 72 hours. R36's care plan was updated to address physical aggression and behavioral tracking. IDT team will monitor and communicate closely with PCP. R36's Progress Notes, dated 08/11/24 at 6:29 PM, documented Physical aggression initiated by resident. No injuries. Facility administration, Power of Attorney (POA), and medical doctor (MD) aware. On 10/30/24 at 1:40 PM, R36 said R48 came up and grabbed the cart that had water on it, and he thought R48 was going to turn it over, so he reached up and grabbed at it to keep him from turning it over. He said he doesn't remember hitting R48 or R48 hitting him. V1 Administrator stated she would expect the staff to separate the residents immediately if there was a resident-to-resident altercation. They should also notify the nurse so they can do a nursing assessment, and to contact her. She said when R48 first arrived at the facility he was placed back on the locked unit and within eight hours he was involved in a resident-to-resident altercation. She said it was too close of quarters back there for him. V1 stated that hospice is going to get more involved with R48's care and as a team they are going to work together to hopefully make things better. She said hospice is going to have volunteers to come out and sit 1:1 with R48. 40701 3. On 10/28/24 at 3:51 PM, R17 stated, (R48) has hit (R37) and (R11). He threw a soda bottle at me, but it didn't hit me. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/30/24 at 9:51 AM, R37 stated, (R48) head butt me. It hurt. He has a hard head. I wasn't expecting it. (V19) heard and turned so fast. She got him away from me. I didn't do anything to him, but I wanted to. My grandsons wanted me to as well after hearing about it. I just told him not to put his fingers in the milk glass. I didn't raise my voice or anything. He has come into my room but now I have a sign up. He followed me everywhere I would go. I sat with him for 3 hours, 2 hours the next day and 1 hour the next day just to keep him occupied while they (staff) did whatever. I don't get paid for it. On 10/30/2024 at 11:20 PM, V19, Housekeeping, stated, It was my third day here (employed at the facility). I was cleaning the dining room. I heard (R37) tell (R48) to 'back off'. I turned around and he started (did an elbowing motion) going like this a couple times. She (R37) said, 'stop I'm going to fall. I fall easy'. I told (R48) to 'come here'. I told the CAN (unknown Certified Nursing Assistant) (R48) hit (R37) so she told the nurse. She was very upset. I think it hurt her arm but not enough to cause her to be sent out to the hospital or anything. The Facility's IDPH (Illinois Department of Public Health) Notification Form dated 9/29/2024 at 8:00 AM documents, Unwitnessed resident on resident altercation. The Facility's Final Investigation dated 10/3/2024 documents R37 is alert, oriented x's 3 (person, place, time) and has independent decision-making skills. It further documents R48 has severe cognitive impairment. It continues, On September 29th, 2024 at approximately 8:00 AM, a staff member was alerted to (R37), who was getting ice from the ice machine in the main dining area. (R37) and (R48) were observed side by side at the ice cooler by staff member, (V19). (R37) stated he (R48) had elbowed her shoulder 3xs. [NAME] was redirected away from the area and nurse was notified. (R37) reported to nurse that (R48) elbowed her 3xs on her right upper arm. It continues to document, Staff Statements: (V19) (Housekeeper): I was cleaning the dining room and heard (R37) raise her voice at (R48) telling him to stop or she was going to fall. I went to redirect resident and saw (R48) nudging (R37) in her right arm with his elbow. I guided (R48) away from (R37) and alerted the nurse. and (V26) (CNA): I was feeding in the dining room. Resident, (R37) reported to me she was hit by (R48). I asked the resident if she was ok, she stated I am fine, he just shoved me but it scared me. I helped assist (R48) from the dining room. A couple of hours later I checked on (R37), to make sure she was doing ok. (R37) stated she was doing ok but her forearm is sore. I reported this to nurse. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Facility's Abuse Prevention Program policy, revised 11/28/16, documented Policy This facility affirms the rights of our residents to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined below. This includes, but is not limited to, freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. This facility therefore prohibits mistreatment, exploitation, neglect or abuse of its residents, and has attempted to establish a resident sensitive and resident secure environment. The purpose of this policy is to assure that the facility is doing all that is within its control to prevent occurrences of mistreatment, exploitation, neglect or abuse of out residents. This will be done by: Dementia management and resident abuse prevention. Immediately protecting residents involved in identified reports of possible abuse: implementing systems to investigate all reports and allegations of mistreatment, exploitation, neglect, abuse of residents and misappropriation of resident property; promptly and aggressively and making the necessary changes to prevent future occurrences. It further documented V. Protection of residents. Residents who allegedly mistreat or abuse another resident or misappropriate resident property will be removed from contact with that resident during the course of the investigation. The accused resident's condition shall be immediately evaluated to determine the most suitable therapy, care approaches and placement considering his or her safety, as well as the safety of other residents and employees of the facility.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Rose Garden of Pana	900 South Chestnut Pana, IL 62557

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. 49494 Based on interview, observation, and record review, the facility failed to update R47's care plan with new fall prevention interventions for 1 resident (R47) of 14 residents whose care plans were reviewed in the sample of 17. Findings Include: R47's face sheet dated 10/30/24 documented R47 has diagnoses of Alzheimer's disease, major depressive disorder, anxiety disorder, hypertension, and osteoporosis. R47's MDS (Minimum Data Set) dated 9/8/24 documented R47 is severely cognitively impaired. R47's care plan with a print date of 10/29/24 documented the resident has had an actual fall with no apparent injury. This care plan does not address R47's fall with injury that occurred on 9/30/24 including a root cause analysis and new fall prevention interventions. R47's progress note dated 9/30/24 at 4:30 am documented resident today fell on shift at 0400 while ambulating in hallway. When staff turned around, resident was standing behind staff became startled and spun around tripping over own feet. When falling resident hit her head into the corner of the hand railing on the wall and then fell to the ground. Upon assessment resident was noted to have a small laceration of L (left) brow bone that measured 1.5 cm by 2 cm and two skin tears on L hand. One measure 5.5 cm x 7.5 cm on the top of the hand and a 1 cm x 1 cm on the knuckle. Resident neuro assessment was without abnormalities from baseline. Resident was alert, PERRLA (pupils equal, round, and reactive to light) was present, grips moderate and equal, and opened eyes spontaneously. Manager on call notified with message left at 4:13 am. MD (Medical Doctor) notified of situation at 4:19 am and gave order to be evaluated in ED (Emergency Department), POA (Power of Attorney) made aware of situation at 4:25 am. Vital signs were within normal range, no other injuries present at time. Resident transferred to local hospital via ambulance for evaluation. R47's progress note dated 9/30/24 at 7:30 am documented resident returned from the ER (emergency room). CT (computed tomography) scan came back negative. Has a laceration above left eye that had steristrips that she was picking off when she returned along with steristrips to skin tears to left hand. R47's EMR (Electronic Medical Record) does not document any post fall neurological assessments for R47's fall on 9/30/24. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/30/24 at 12:42 PM V5 (Care Plan Coordinator) stated that she was not aware of R47's fall on 9/30/24 and that she did not update R47's care plan with any new fall interventions after the fall on 9/30/24. V5 stated that the floor nurse did not complete an incident report in the EMR (electronic medical record) risk management program and therefore she was not aware of the fall. V5 stated that she does expect the nurses to always complete an incident report in the EMR risk management program. V5 stated that since R47 hit her head she would have expected the nurses to complete neurological assessments on R47 for 72 hours and that they were not completed on R47 after her fall on 9/30/24. V5 stated that the fall process is supposed to be for the floor nurse to complete the incident report, V4 (Resident Care Coordinator) completes the root cause analysis and interventions, and she updates the care plan with the new interventions. V5 stated that none of these were completed on R47's fall that occurred on 9/30/24. On 10/30/24 at 12:50 pm V1 (Administrator) stated that she expects the nurses to complete an incident report with each fall and that it was not completed for R47's fall that occurred on 9/30/24. 10/30/24 at 1:05 pm V4 (Resident Care Coordinator) stated that she expects the nurses to complete an incident report in the EMR risk management program with each resident fall and that there was not one completed for R47 therefore she did not know she fell , didn't investigate the fall, and did not add any interventions to R47's care plan. The facility's Comprehensive Care Planning policy dated 7/20/22 documented it is the policy of the facility to comprehensively assess and periodically reassess each resident admitted to this facility. The results of the resident assessment shall serve as the basis for determining each resident's strengths, needs, goals, life history and preferences to develop a person center comprehensive plan of care for each resident that will describe the services that are to be furnished to attain or maintaining the resident's highest practicable physical, mental, and psychosocial well-being. It continues, 5. Program Plan - A structured program designed to change a specific need/problem. The Program Plan consists of, at minimum: a. Statement of the targeted problem/need. b. Goal stating the expected outcome of the reduction of the targeting problem. C. Interventions/Approaches aimed at reducing the causative factors of the targeted problem. It continues, 9. The resident care plan may be kept electronically or in hard copy printed format. a. Problems, goals and interventions should include the date initiated for ease of reference. b. All intervention entries should include the date the care intervention was initiated by the staff as well as the date the intervention was added to the care plan if added after the original care plan date. The facility's Fall Prevention policy dated 11/10/18 documented it is the policy to provide for resident safety and to minimize injuries related to falls; decrease falls and still honor each resident's wishes/desires for maximum independence and mobility. Responsibility: all staff. Procedure: 1. Conduct fall assessments on the day of admission, quarterly, and with a change in condition. 2. Identify, on admission, the resident's risk for falls. It continues, 5. Immediately after any resident fall the unit nurse will assess the resident and provide any care or treatment needed for the resident. A fall huddle will be conducted with staff on duty to help identify circumstances of the event and appropriate interventions. 6. The unit nurse will place documentation of the circumstances of a fall in the nurse's notes or on an AIM for Wellness form along with any new intervention deemed to be appropriate at the time. The unit nurse will also place any new intervention on the CNA (Certified Nurse Assistant) assignment worksheet. 7. Report all falls during the morning Quality Assurance meetings Monday through Friday. All falls will be discussed in the Morning Quality Assurance meeting and any new interventions will be written on the care plan.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44556 Based on interview, observation, and record review, the facility failed to complete an incident report, failed to investigate, and determine the root cause of the fall, and failed to implement new fall prevention interventions. The facility also failed to provide adequate supervision to prevent resident from wandering into other resident's rooms on multiple occasions for 2 (R47 and R48) of 4 residents reviewed for falls/supervision in a sample of 27. Findings include: 1. R48's Face Sheet, with a print date of 10/30/24, documented R48 has diagnoses of but not limited to unspecified, dementia, mild, with agitation, chronic obstructive pulmonary disease (COPD), Depression, and anxiety disorder. R48's MDS, dated [DATE], documented R48 is severely cognitively impaired and requires supervision/touching assistance with eating, partial/moderate assistance with sitting to lying, lying to sitting. sitting to standing, transfer, substantial/maximal assistance with oral hygiene, upper body dressing, dependent with toileting hygiene lower body dressing, putting on/taking off footwear, personal hygiene, rolling left/right, and he is always incontinent of bowel and bladder. R48's Care Plan, with an admitted [DATE], documented R48 is/has the potential to be physically aggressive related to (r/t) dementia. Interventions include but are not limited to 15-minute checks in common areas and analyze times of day, places, circumstances, triggers, and what de-escalates behavior and document. It also documents R48 is/has the potential to be verbally aggressive r/t dementia. Interventions include but are not limited to Analyze of key times, places, circumstances, triggers, and what de-escalates behavior and document, assess, and anticipate resident's needs: food, thirst. toileting needs, comfort level, body positioning, pain etc., monitor behaviors every shift. Document observed behavior and attempted interventions, and when the resident becomes agitated: Intervene before agitation escalates; Guide away from source of distress; Engage calmly in conversation; If response is aggressive, staff to walk calmly away, and approach later. It also documented R48 exhibits/has exhibited in past a tendency to seek to leave facility or wander near exits. Specific behavior exhibited, wandering, following staff or resident's, going into other resident's rooms. Interventions include but are not limited to 1:1 close and constant or continuous visual monitoring when resident is agitated and not easily redirected, accompany resident when desires to leave unit, be alert for need of assistance, give verbal cues for direction as needed, guide Resident to safe walking locations away from exits, and intervene as needed to ensure residents/others safety. R48's Progress Notes, dated 9/27/2024 at 11:01 AM, documented Behavior Note: Resident entered a female's resident room and was agitated at staff when being redirected. Female resident was upset that resident would not leave room. Resident left room after multiple attempts by staff. R48's Progress Notes, dated 9/27/2024 at 2:15 PM, documented Behavior Note: Heard a female resident yelling and upon entering her room found R48 in her room while she was using the bathroom. Removed resident from her room. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R48's Progress Notes, dated 10/20/2024 at 08:45 AM, documented Behavior Note: Patient restless, wandering facility. Resident has attempted to enter other resident's rooms and urinated on floor. All redirections are met with physical aggression towards staff. Writer was hit during medication administration as well, but pt (patient) did eventually take all medications including as needed (PRN) Lorazepam. On 10/28/24 at 1:43 PM, R48 was observed wandering up and down the 100 hallway with no staff supervision. On 10/28/24 at 1:46 PM, R48 was observed wandering on the 100 hallway and was observed going into one of the rooms on the hall. He remained in room for several minutes with no staff attempting to find or check on him. On 10/28/24 at 2:00 PM, R48 was observed wandering back out on the 100 hallway. On 10/28/24 at time unknown R48 attempted to get out the smoker's door. You must have a code to get in and out of the door and it is not a fenced in courtyard. On 10/28/24 at 3:25 PM, R48 was observed wandering down the 400 hallway. On 10/28/24 at 3:56 PM, R48 was observed still wandering the facility. He was observed touching the smoker's door which is located on the 200 hallway. On 10/30/24 at 08:02 AM, R48 was observed ambulating down the hallway unattended and then attempting to open dietary door on 400 hallway. On 10/29/24 at 11:13 AM, R14 stated about a month ago, R48 came into her room, sat on the spare bed, and started to take off his shoes. R14 stated she told R48 to stop, he was in the wrong place, but he proceeded to take off his shirt. R14 stated she then had to press her call light to get staff to help get him out of her room. On 10/29/24 at 11:15 AM, R36 stated R48 came into his bedroom claiming it was his even though R36 told him it was not. R36 stated he had to call staff in to remove R48 but can't remember when this happened. R36 stated R48 wandered up to his dining table and took his tea one time also. On 10/29/24 at 11:18 AM, R12 stated R48 has wandered into her room, and she feels like his wandering is getting worse. R12 stated R48 tries to take other resident's food and drinks; he tried taking her water one day. R12 stated R48 doesn't listen to staff even if they are there. R12 continued stating R48 continues to do whatever he wants, there isn't anyone here that is able to take care of him and his sister tries to intervene because she is also a resident here. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 10/30/24 at 9:04 AM, V17 (R48's wife) was contacted at this time. She said when R48 was admitted to the facility he was back on the locked unit and he went crazy. She said there wasn't enough room for him to walk and he likes to walk a lot, so they moved him out onto the other hall. V17 said she has suggested they try putting him back on the unit for a few hours a day and then work up to more hours until he is able to stay back there but the facility said they didn't want to be responsible for him hitting anyone because the last time he was back there he did hit someone and urinated on some lady's locker or something. V17 stated R48 should be a 1:1 but they have only made him a 1:1 for a week or two at a time then taken him off. She said the only reason he was a 1:1 yesterday (10/29/24) was because the state surveying agency was in the building, and they made him one after they found him in the therapy room that morning on the floor. She said there has been time they didn't know where R48 was at, and she said one night at 9:00 PM they found him in the kitchen by himself. On 10/30/24 at 12:46 PM, R11 stated R48 wanders up and down the hallways all the time. R11 said one night she woke up at around 12:30 AM to go to the bathroom and as she was standing up, she just happened to look down and seen two feet. She said she knew they were R48's feet that were standing there and it kind of scared her. She said one time he even walked in on her while she was using the bathroom. V11 said she told one of the nurses that if R48 were to hit her it would be over for her due to her being so weak and unsteady on her feet. On 10/31/24 at 1:40 PM, V1 (Administrator) stated she would expect the staff to try and redirect the resident from wandering into another resident's room. She said they will sometimes place the resident 1:1 with activities or even social service if they don't have enough staff to do it. She said they try to give R48 1:1 attention and try to redirect him elsewhere. She said they have had R48 on 1:1 the last couple of days due to medication changes being done. V1 said R38 will get focused on one room, and they will have to put a stop sign across the door. On 10/31/24 at 1:34 PM V5 (MSD Coordinator) stated the facility doesn't have a policy on wandering they have one regarding elopement but not wandering. 49494 2. R47's face sheet dated 10/30/24 documented R47 has diagnoses of Alzheimer's disease, major depressive disorder, anxiety disorder, hypertension, and osteoporosis. R47's MDS (Minimum Data Set) dated 9/8/24 documented R47 is severely cognitively impaired. R47's care plan with print date of 10/29/24 documented resident has risk factors for falls that require monitoring and intervention to reduce potential for self-injury. Risk factors include dementia, unaware of safety needs as evidenced by diagnosis. It continues the resident has had an actual fall with no apparent injury. Root cause may be related to cognitive impairment - unaware of safety needs. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R47's progress note dated 9/30/24 at 4:30 am documented resident today fell on shift at 0400 while ambulating in hallway. When staff turned around, resident was standing behind staff became startled and spun around tripping over own feet. When falling resident hit her head into the corner of the hand railing on the wall and then fell to the ground. Upon assessment resident was noted to have a small laceration of L (left) brow bone that measured 1.5 cm by 2 cm and two skin tears on L hand. One measure 5.5 cm x 7.5 cm on the top of the hand and a 1 cm x 1 cm on the knuckle. Resident neuro assessment was without abnormalities from baseline. Resident was alert, PERRLA (pupils equal, round, and reactive to light) was present, grips moderate and equal, and opened eyes spontaneously. Manager on call notified with message left at 4:13 am. MD (Medical Doctor) notified of situation at 4:19 am and gave order to be evaluated in ED (Emergency Department), POA (Power of Attorney) made aware of situation at 4:25 am. Vital signs were within normal range, no other injuries present at time. Resident transferred to local hospital via ambulance for evaluation. R47's progress note dated 9/30/24 at 7:30 am documented resident returned from the ER (emergency room). CT (computed tomography) scan came back negative. Has a laceration above left eye that had steristrips that she was picking off when she returned along with steristrips to skin tears to left hand. R47's EMR (Electronic Medical Record) does not document any post fall neurological assessments for R47's fall on 9/30/24. On 10/30/24 at 12:42 PM V5 (Care Plan Coordinator) stated that she was not aware of R47's fall on 9/30/24 and that she did not update R47's care plan with any new fall interventions after the fall on 9/30/24. V5 stated that the floor nurse did not complete an incident report in the EMR (electronic medical record) risk management program and therefore she was not aware of the fall. V5 stated that she does expect the nurses to always complete an incident report in the EMR risk management program. V5 stated that since R47 hit her head she would have expected the nurses to complete neurological assessments on R47 for 72 hours and that they were not completed on R47 after her fall on 9/30/24. V5 stated that the fall process is supposed to be for the floor nurse to complete the incident report, V4 (Resident Care Coordinator) completes the root cause analysis and interventions, and she updates the care plan with the new interventions. V5 stated that none of these were completed on R47's fall that occurred on 9/30/24. On 10/30/24 at 12:50 pm V1 (Administrator) stated that she expects the nurses to complete an incident report with each fall and that it was not completed for R47's fall that occurred on 9/30/24. 10/30/24 at 1:05 pm V4 (Resident Care Coordinator) stated that she expects the nurses to complete an incident report in the EMR risk management program with each resident fall and that there was not one completed for R47 therefore she did not know she fell , didn't investigate the fall, and did not add any interventions to R47's care plan. On 10/29/24 at 1:42 PM V4 (Resident Care Coordinator) stated they must have missed R47's fall on 9/30/24 because it was not put into the risk management system. V4 stated that R47's fall on 9/30/24 was not investigated to determine the root cause nor was a new intervention put into place to prevent further falls. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The facility's Fall Prevention policy dated 11/10/18 documented it is the policy to provide for resident safety and to minimize injuries related to falls; decrease falls and still honor each resident's wishes/desires for maximum independence and mobility. Responsibility: all staff. Procedure: 1. Conduct fall assessments on the day of admission, quarterly, and with a change in condition. 2. Identify, on admission, the resident's risk for falls. It continues, 5. Immediately after any resident fall the unit nurse will assess the resident and provide any care or treatment needed for the resident. A fall huddle will be conducted with staff on duty to help identify circumstances of the event and appropriate interventions. 6. The unit nurse will place documentation of the circumstances of a fall in the nurse's notes or on an AIM for Wellness form along with any new intervention deemed to be appropriate at the time. The unit nurse will also place any new intervention on the CNA (Certified Nurse Assistant) assignment worksheet. 7. Report all falls during the morning Quality Assurance meetings Monday through Friday. All falls will be discussed in the Morning Quality Assurance meeting and any new interventions will be written on the care plan.

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F 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis. 40701 Based on interview, observation, and record review the Facility failed to provide a Registered Nurse (RN) for at least 8 consecutive hours a day, 7 days a week. The facility also failed to employ a Director of Nursing (DON). This has the potential to affect all 53 residents in the facility. Findings include: On 10/28/2024 at 9:20 AM V1 (Administrator) stated, We do not currently have a DON and I can tell you we do not have enough RN coverage. We only have one (RN) who works 3 days a week. V1 stated the Facility census was 53. The Facility's Management Team document, undated, documents the DON position is vacant. During this survey 10/28/24-10/31/24, there were no observation of a DON at the Facility. There were also no observations of a RN on duty. On 8/30/2024 at 11:00 AM, V5 (Licensed Practical Nurse/LPN) stated, (Former DON)'s last day was 7/25/2024. We had a DON hired, but she only stayed 2 hours and never completed her (employment) paperwork. (V15 RN) is our only RN and works Fridays, Saturdays and Sundays. V15's Master Schedule documents V15 did not work 10/1/2024, 10/2/2024, 10/3/2024, 10/7/2024, 10/8/2024, 10/9/2024, 10/10/2024, 10/14/2024, 10/15/2024, 10/16/2024, 10/27/2024, 10/21/2024, 10/22/2024, 10/23/2024, or 10/24/2024. This documents the days V15 did not work, there was no RN coverage for 8 hours a day. The CMS 671 Form dated 10/28/2024 documents there are 53 residents residing at the Facility. The Facility's Nurse Staffing policy, undated, documents It is the policy of (Facility's) Health Care to provide sufficient licensed and unlicensed nursing staff on each shift of the day to attain or maintain the highest practical physical, mental and psychosocial well-being of each resident. Nurse staffing shall be based upon resident evaluation by the Administrator and Director of Nursing as specified by the Illinois Department of Public Health.

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F 0732 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Post nurse staffing information every day. 40701 Based on observation, interview and record review, the Facility failed to ensure the daily nursing staff hours were posted and easily visible to residents. This failure has the potential to affect all 53 residents residing in the Facility. Findings include: On 10/28/2024 at 9:20 AM V1 (Administrator) stated the Facility census was 53. On 10/28/2024, 10/29/2024, 10/30/2024 and 10/31/2024 the survey team made observations throughout the Facility. There were no postings observed to document the resident census and the number of licensed nursing staff. On 10/31/2024 at 10:40 AM, V1 stated V1 thought the former Director of Nursing (DON) posted the nurses schedules at the nurses' station. V1 stated she was not aware it was not being posted for the week. On 10/31/2024 at 10:53 AM, V5 (Licensed Practical Nurse/LPN) stated, It used to be posted on the DON's office door, which is now V4's (LPN/Resident Care Coordinator) door. (Former DON) was doing it. It should be done by the person who is doing the schedule. It should be kept current and posted every day. The CMS 671 Form dated 10/28/2024 documents there are 53 residents residing at the Facility.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50908 Based on interviews, observations, and record reviews the facility failed to label, date, and dispose of food items stored in the refrigerator and freezer with potential to affect 4 out of 4 residents (R2, R7, R18, and R23) reviewed for expired food in a sample of 17. Findings include: On [DATE] at 9:15 AM, during the initial walk through of the kitchen, the following items were found in the refrigerator and freezer: 1. Pears with open date of [DATE]. 2. Opened Thick and Easy Hormel Orange Juice Thickened with no open date or use by date. 3. Opened Thick and Easy Hormel Apple Juice Thickened with no open date or use by date. 4. Mini cinnamon swirls frozen with freezer burn, undated. 5. Sugar snap peas frozen with freezer burn, undated and unlabeled. 6. Bananas for cake or muffins frozen with freezer burn, dated [DATE]. 7. Sugar cookies frozen undated and unlabeled. R23's Physician Orders with a start date of [DATE], documented a diet order of regular food with regular/thin liquid fluid consistency. R2's Physician Orders with a start date of [DATE], documented a diet order of regular food with regular/thin liquid fluid consistency. R18's Physician Orders with a start date of [DATE], documented a diet order of regular with honey/moderately thick fluid consistency. R7's Physician Orders with a start date of [DATE], documented a diet order of regular, pureed texture, and pudding/extremely thick fluid consistency. On [DATE] at 9:15 AM, V3 (Dietary Manager) stated their practice is to usually keep the fruit in the refrigerator for a week. V3 stated the date the thickened juices were received was written but they were unsure if an open date needed to be written also. On [DATE] at 2:08 PM, V3 stated any item found that is undated, without a label or has freezer burn should be thrown away. V3 stated she would have expected this to be done. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145411	A. Building B. Wing	10/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Rose Garden of Pana	900 South Chestnut Pana, IL 62557

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The facility's Refrigerator and Freezer Storage Policy, with last revision date of ,d+[DATE], documented it is the facility's policy that any item to be placed in the refrigerators and freezers must be covered, labeled, and dated with a date-marking system that tracks when to discard perishable foods. The policy further documented the procedure is to mark each container with name of item and mark the date that the original container is opened or date of preparation. The facility's Storage Policy, with last revision date of ,d+[DATE], documented its procedure is to store leftovers in covered, labeled, and dated containers under refrigeration or frozen.