STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 3000408	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 10/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROSE GARDEN OF PANA	900 SOUTH CHESTNUT , PANA, Illinois, 62557

(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
S0000	Initial Comments Complaint Investigation: 25410414/2651018	S0000		11/07/2025
S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.1010h) 300.1210b) 300.1210d)3) 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 300.1010 Medical Care Policies h) The facility shall notify the resident's physician of any accident, injury, or significant change in a resident's condition that threatens the health, safety or welfare of a resident, including, but not limited to, the presence of incipient or manifest decubitus ulcers or a weight loss or gain of five percent or more within a period of 30 days. The facility shall obtain and record the physician's plan of care for the care or treatment of such accident, injury or change in condition at the time of notification.	S9999		11/07/2025

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

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S9999	Continued from page 1 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 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. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the Facility failed to assess a resident with a change in condition for 1 of 3 residents (R2) reviewed for quality of care in the sample of 3. The facility also failed to notify the physician and resident representative of a change of condition. This failure resulted in a delay in hospitalization for R2 for the diagnoses of small bowel obstruction, dehydration, nausea, and vomiting. R2 required nasogastric decompression and endured three attempts at midline catheter placement to achieve intravenous access for fluid resuscitation. Findings include: R2's Face Sheet documents R2 was admitted to the Facility on 9/15/25 with diagnoses including dementia, chronic kidney disease, and congestive heart failure. R2's Minimum Data Set (MDS) dated 9/24/25 documented R2 was moderately cognitively impaired and required substantial assistance with bed mobility and transfer. On 10/23/25 at 4:35 PM, V9 (R2's Family) stated she came to visit R2 over the weekend of 10/10/25-10/11/25.	S9999		

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S9999	Continued from page 2 R2 was asleep in the dining room which was unusual for her. V9 did not see R2 vomit that day, but when she was admitted to the hospital on 10/15/25, hospital staff told her the Facility reported R2 had been vomiting for three days prior to admission. On 10/24/25 at 12:30 PM, V2 (Director of Nursing/DON), stated R2 did not have a known history of nausea or vomiting. On 10/24/25 at 12:52 PM, V12 (Memory Care Coordinator) stated R2 was vomiting during breakfast on 10/14/25, and V7 (Licensed Practical Nurse/LPN) was notified. On 10/24/25 at 12:59 PM, V10 (Certified Nursing Assistant/CNA), stated R2 vomited during dinner on 10/11/25 and did not eat breakfast or lunch on 10/12/25. On 10/24/25 at 1:55 PM, V13 (CNA) stated R2 was not feeling well on 10/12/25 and was not eating her meals. R2's Progress Note by V7 (LPN) on 10/14/25 at 5:23 PM documents, "Resident has had emesis x2 today, food contents mixed with stomach acids. She states she doesnt {sic} feel to {sic} bad. Will put a call into MD (Medical Doctor) in the AM" On 10/24/25 at 1:07 PM, V7 (LPN) stated she had been off work for a few days and had no knowledge of R2 having any gastrointestinal issues. She stated, "(Nursing) reports aren't always the greatest because we have agency, and they are not always the best." V7 stated R2 was alert and said she did not feel too bad, so she went on to finish her medication pass. She did not assess R2's abdomen for bowel sounds or distention and was unsure of the time of R2's last bowel movement. She worked until around 6:00 PM and gave report to V6 (LPN) with a plan to call the doctor the next day. R2's Progress Note by V6 (LPN) on 10/15/25 at 2:02 AM documents, "Res (resident) had emesis x3 this shift. Vitals still WNL (Within Normal Limits). Bowel sounds present. Res c/o (complained of) LUQ (Left Upper Quadrant) pain upon palpations. Attempted to push fluids this evening, res would feel nauseous after a sip. Res c/o of being light headed. Res has had increased confusion, trying to climb out of the recliner and yelling." R2 was send to (Local Hospital) for further evaluation. On 10/24/25 at 10:53 AM, V6 was unavailable for interview.	S9999		

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S9999	Continued from page 3 R2's (Local) Hospital Records dated 10/15/25 R2 was having nausea and vomiting for several days prior to admission and had large protuberant abdomen on examination. Computed Tomography (CT) Scan showed small bowel obstruction. Nasogastric tube was placed for gastric decompression, and midline catheter required three attempts to achieve intravenous access for fluid resuscitation. Emergency Room physician notes for the "assessment/plan" documents, "1. Small bowel obstruction. 2. New onset atrial fibrillation. 3. Elevated troponin. 4. Nausea & Vomiting. 5. Hyperkalemia. 6. Dehydration. 7. Chronic kidney disease, stage 3. 8. Urinary tract infection. 9. Lactic acidosis." Discharge Disposition: transferred to (higher level of care hospital name) ICU (intensive care unit). On 10/24/25 at 2:10 PM, V11 (Medical Doctor/MD), stated he would have expected Facility nurses to examine R2's abdomen, listen for bowel sounds, check for distention and tenderness, and call him with any changes in condition. On 10/28/25 at 11:20 AM, V2 (DON) stated nursing staff did what they should have and there was no delay in R2's hospitalization. V2 stated the physician does not need to be contacted just because a resident has emesis. V9 (R2's Family) was in the Facility visiting R2 all weekend and knew she had been doing fine. Staff called V9 when R2 went to the hospital. The Facility does not have a policy specific to gastrointestinal assessment. The Facility's "Change in a Resident's Condition or Status" Policy dated 2001 documents, "Our facility promptly notifies the resident, his or her attending physician, and the resident representative of changes in the resident's medical/mental condition and/or status." "B"	S9999		