

Illinois State Department of Health

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 02/26/2026	
NAME OF PROVIDER OR SUPPLIER ROSE GARDEN OF PANA				STREET ADDRESS, CITY, STATE, ZIP CODE 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		S0000				
	Annual Health Survey						
S9999	Final Observations		S9999				
	Statement of Licensure Violations:						
	300.610a)						
	300.1210a)						
	300.1210b)						
	300.1210c)						
	300.1210d)2)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 300.1210 General Requirements for Nursing and Personal Care						
	a) Comprehensive Resident Care Plan. A facility, with the participation of the resident and the resident's guardian or representative, as applicable, must develop and implement a comprehensive care plan for each resident that includes measurable objectives and timetables to meet the resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment, which allow the resident to attain or maintain the highest practicable level of independent functioning, and						

Office of Primary Care and Health Systems Management

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

Illinois State Department of Health

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 02/26/2026	
NAME OF PROVIDER OR SUPPLIER ROSE GARDEN OF PANA				STREET ADDRESS, CITY, STATE, ZIP CODE 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	
S9999	Continued from page 1 provide for discharge planning to the least restrictive setting based on the resident's care needs. The assessment shall be developed with the active participation of the resident and the resident's guardian or representative, as applicable. (Section 3-202.2a of the Act) 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. c) Each direct care-giving staff shall review and be knowledgeable about his or her residents' respective resident care plan. 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: 2) All treatments and procedures shall be administered as ordered by the physician. 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 observation, interview, and record review the facility to manage pain for 1 of 3 (R3) residents reviewed for pain management in a sample of 41. This failure resulted in R3 experiencing unrelieved horrible pain. Findings include: R3's Care Plan, dated 10/16/2026, documents PAIN: The resident has occasional pain r/t (related to) T2DM (type 2 diabetic), heart disease, BPH (benign prostatic hyperplasia), HTN (hypertension), muscle weakness, HLD (Hyperlipidemia), and calcaneal spur to right foot. It also documents Administer analgesia as per orders. Give 1/2 hour before treatments or care. Anticipate the resident's need for pain relief and respond immediately		S9999				

Illinois State Department of Health

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 02/26/2026	
NAME OF PROVIDER OR SUPPLIER ROSE GARDEN OF PANA				STREET ADDRESS, CITY, STATE, ZIP CODE 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
S9999	Continued from page 2 to any complaint of pain. Evaluate pain relief 30-60 minutes after administering analgesics (depending on route). R3's Minimum Data Set, dated 2/4/2026, documents that R3 has pain. R3's Physician order, dated 9/30/2025, documents Heel Protectors on while in bed. On 2/23/2026 at 10:12 AM observed R3 lying on back in bed on his back with heels on mattress. Observed heel protectors in chair next to bed. From 10:30 AM to 2:00 PM using 15 to 30-minute intervals. R3 was observed laying in the bed on his back with both heels pressing against mattress with heel protectors in chair. On 2/23/2026 at 10:12 AM R3 stated that he had sores and blisters to his legs and heels. R3 stated that he was told by the nurse that the areas are closed but not healed. R3 stated that his heels hurt a lot. R3 stated that the pain is horrible. R3 stated that he couldn't get relief because his heels press on the bed. R3 stated that he can't give me a number but it hurts very much and he is unable to get relief. On 2/23/2026 at approximately 11:40 AM R3 stated that his feet feel better. R3 stated that he had been given some pain medication for his stomach earlier, but it didn't help his heels. R3 stated said that since putting on the heel protector the pain is better. R3 stated that it feels like his feet are on air. "He feels nothing." On 2/25/2026 at 8:15 AM observed R3 lying on back in bed on his back with heels on mattress. Observed heel protectors in chair next to bed. At 10:16 AM observed R3 lying on back in bed on his back, heels on mattress with heel protectors in chair next to bed. At 11:02 AM observed R3 lying on back in bed on his back, heels on mattress with heel protectors in chair next to bed. At 11:12 AM the heel protectors were applied to R3's feet. On 2/25/2026 at 11:08 AM V3 (Assistant Director of Nursing/ADON), stated that R3 is to always have the heel protectors on when in bed. On 2/25/2026 12:34 PM V5 (Licensed Practical Nurse) stated that R3 is alert. V5 stated that he does have times when he is forgetful. V5 stated that R3 knows when he is in pain and can communicate his pain accurately. V5 stated that R3 has received a new order for pain. The facility's Pain Assessment and Management Level III Purpose policy documents that The purposes of this			S9999			

Illinois State Department of Health

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 02/26/2026	
NAME OF PROVIDER OR SUPPLIER ROSE GARDEN OF PANA				STREET ADDRESS, CITY, STATE, ZIP CODE 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
S9999	Continued from page 3 procedure are to help the staff identify pain in the resident, and to develop interventions that are consistent with the resident's goals and needs and that address the underlying causes of pain. General Guidelines 1. The pain management program is based on a facility-wide commitment to appropriate assessment and treatment of pain, based on professional standards of practice, the comprehensive care plan, and the resident's choices related to pain management. 2. "Pain management" is defined as the process of alleviating the resident's pain based on his or her clinical condition and established treatment goals. 3. Pain management is a multidisciplinary care process that includes the following: a. Assessing the potential for pain; b. Recognizing the presence of pain; c. Identifying the characteristics of pain; d. Addressing the underlying causes of the pain; e. Developing and implementing approaches to pain management; f. Identifying and using specific strategies for different levels and sources of pain; g. Monitoring for the effectiveness of interventions; and h. Modifying approaches as necessary. "B"			S9999			