_Illinois D	epartment of Public	Health				
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		IL6012165	B. WING		C 03/06/2019	
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE		
ROSEW	OOD CARE CENTER	OF PEORIA	ST NORTHM IL 61614	OOR ROAD		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ILD BE COMPLETE	
S9999	Final Observations		S9999		j	
	Statement of Licens 1 of 1 Violation	sure Violation:				
	300.610a) 300.1210b) 300.1210d)2)3) 300.1620a) 300.3240a)					
	Section 300.610 R	esident Care Policies				
	procedures governifacility. The written be formulated by a Committee consisti administrator, the a medical advisory confine of nursing and othe policies shall complete the facility and shall be controlled to the policies.	dvisory physician or the ammittee, and representatives r services in the facility. The y with the Act and this Part. shall be followed in operating the reviewed at least annually documented by written, signed				
	Section 300.1210 (Nursing and Persor	General Requirements for nal Care		Attachment /	4	
	care and services to practicable physical well-being of the res	shall provide the necessary of attain or maintain the highest land, and psychological sident, in accordance with apprehensive resident care		Statement of Licensure	<i>l</i> iolations	

Illinois Department of Public Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Electronically Signed

TITLE

(X6) DATE

03/21/19

PRINTED: 04/09/2019 FORM APPROVED Illinois Department of Public Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: _ C B. WING IL6012165 03/06/2019 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1500 WEST NORTHMOOR ROAD **ROSEWOOD CARE CENTER OF PEORIA PEORIA, IL 61614** SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (X5) PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** (EACH CORRECTIVE ACTION SHOULD BE COMPLETE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE DATE TAG **DEFICIENCY**) S9999 Continued From page 1 S9999 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. 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: All treatments and procedures shall be administered as ordered by the physician. 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. Section 300.1620 Compliance with Licensed Prescriber's Orders All medications shall be given only upon the written, facsimile or electronic order of a

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licensed prescriber. The facsimile or electronic

authenticated by the licensed prescriber within 10 calendar days, in accordance with Section 300.1810. All such orders shall have the

handwritten signature (or unique identifier) of the licensed prescriber. (Rubber stamp signatures are not acceptable.) These medications shall be

order of a licensed prescriber shall be

PRINTED: 04/09/2019 FORM APPROVED Illinois Department of Public Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: C B. WING IL6012165 03/06/2019 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1500 WEST NORTHMOOR ROAD **ROSEWOOD CARE CENTER OF PEORIA PEORIA, IL 61614** SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (X5) (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE DATE TAG DEFICIENCY) S9999 Continued From page 2 S9999 administered as ordered-by the licensed prescriber and at the designated time. Section 300.3240 Abuse and Neglect An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. (A, B) (Section 2-107 of the Act) These Requirements are not met as evidenced by: Based on interview and record review the facility failed to administer physician ordered pain medication to one (R1) of three residents reviewed for pain in the sample of three. This failure resulted in R1 experiencing increased pain, inability to sleep, and increased anxiety. Findings include:

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The facility's Pain Management policy, revised 11-2009, documents "In order to provide effective pain management for residents experiencing acute or chronic pain, (The Facility) will implement a comprehensive care process for pain management to include: Anticipating, preventing, minimizing pain; Administering pain medication prudently in order to meet the

resident's pain goals while avoiding unacceptable adverse consequences." The facility's Pain Management procedure, revised 11-2009,

documents "The Nurse will: 4. Provide medication

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLI A. BUILDING:	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		IL6012165	B. WING		03/0)6/2019
NAME OF	PROVIDER OR SUPPLIER	STREET AC	DRESS, CITY, S	TATE, ZIP CODE	1 00,0	0/2013
ROSEW	OOD CARE CENTER	4500 1415	ST NORTHMO			
		PEORIA,	IL 61614			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
S9999	Continued From pa	ge 3	S9999			i -
	as ordered in a time	ely manner."				
	The 6- 40 to 50 to					
	The facility's Medica Documentation, Re					
	documents "3. Doci	ument the omission of a				
		ment for reasons other than				
	MAR/TAR (Medicat	putting his/her initials on the ion Administration				
	Record/Treatment A	Administration Record) sheet				
		the omission of a medication				
		to a medication being t the pharmacy or the				
	supervisor/DON/AD	ON (Director of				
	Nursing/Assistant D	Pirector of Nursing.)"				
	R1's Face Sheet, da	ated 1/10/19, documents R1				
	with following diagn	oses, not limited to:				
		etes Mellitus, Morbid (Severe) itis to left shoulder, Restless				
		osteoarthritis, and Anxiety.				
		•				
	and dated 12/31/18	(Minimum Data Set), signed, documents R1 BIMS (Brief				
	Interview for Mental	Status) as a 15 out of 15				
		nitively intact. This MDS				
		on J0300 - J0400 as having ection J0500 documents "yes"				
	to "limited day-to-da	y activities because of pain."				
	Section J0600 docu	ments R1 with "moderate"				
	care area for R1.	cates "Pain" as a triggered				
		Plan, documents a Problem				
) has potential for alterations ort r/t (related to) Pain" and	5.5			
	"Potential causes of	pain for her may include:				
		extremity) lymphedema,				
		int pain, falls, immobility." The				

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meds as ordered."

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<u> Illinois L</u>	Department of Public	Health					
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION				(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		JL6012165	B. WING			C 06/2019	
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS CITY S	TATE, ZIP CODE	_1	00/2013	
		4500 14/50	ST NORTHMO				
KO2EW	OOD CARE CENTER	DF PEORIA PEORIA,					
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETE DATE	
S9999	Continued From pa	ge 4	S9999				
	R1's POS (Physician's Order Sheet), dated 2/11/19, documents a Physician Order for "Lyrica 25mg (milligrams) by mouth TID (three times daily)" for "Nerve Pain."						
	documentation that	ated February 2019, includes R1's Lyrica was not given s ordered from 2/20/19					
	2/21/19 at 11:05 pm Lyrica unavailable."	e's Progress Notes, dated , documents "Scheduled Note dated 2/22/19 at 6:00 rica at this time not available."					
	documents R1's Lyr	ping Manifest for R1, ica order was received on and was received by the erified by signature.					
	R1 "pain control goa	ent, dated 1/10/19, documents al" as a "4" out of ten on the with 10 being the "worst					
	25mg was increased twice a day, on 2/11. dose was not helpin did not receive (R1's 2/23/19 and when (F pharmacy had not b pain was generally a during these dates (to ten" on the 0-10 m stated (R1) was una	m, R1 stated (R1's) Lyrica d to three times a day, from /19 because the previous g (R1's) pain. R1 stated (R1) s) Lyrica on 2/20/19 through R1) asked (R1) was told the rought it yet. R1 stated (R1's) "three or four" out of ten but R1's) pain ranged from "eight tumerical pain scale. R1 ble to sleep, legs were and (R1's) "anxiety went					

R6P711

	Department of Public	<u>Health</u>					
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		IL6012165	B. WING			C 06/2019	
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE	1 03/1	00/2019	
ROSEW	OOD CARE CENTER	OF PEORIA 1500 WES	ST NORTHN	OOR ROAD			
(7.0.15	CHINA DV OTA	PEORIA,					
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE	
S9999	Continued From pa	ge 5	S9999				
:5	Nursing) stated R1 twice a day for (R1's helping much so it was day. V2 stated he has they are to notify the DON if a resider available. V2 stated yesterday 3/5/19 wt (R1's) room to talk. On 3/6/19 at 3:45pm stated the 2/23/19 do card represents the the Physician's sign.	am, V2 DON (Director of was receiving Lyrica 25mg s) leg pain but it wasn't was increased to three times a as inserviced the Nurses that e physician, the pharmacy and nt's medication is not he was not made aware until nen R1 asked him to come to m, V8 Pharmacy Technician, date on R1's Lyrica medication date the Pharmacy received ed order for (R1's) Lyrica and delivered to the facility that					
		(B)					