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	10/28/2025

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 0684 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. (continued on next page)

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.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0684 Level of Harm - Actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 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 [DATE] with diagnoses including dementia, chronic kidney disease, and congestive heart failure.R2's Minimum Data Set (MDS) dated [DATE] 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. 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 [DATE], 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 AMOn 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.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.