STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145759	A. BUILDING _____ B. WING _____	10/30/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROSICLARE REHABILITATION & HCC	**FERRELL ROAD, PO BOX 220 ROSICLARE, IL 62982**

(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
F 000	INITIAL COMMENTS Annual Licensure / Certification Survey.	F 000		
F 221 SS=D	483.13(a) RIGHT TO BE FREE FROM PHYSICAL RESTRAINTS The resident has the right to be free from any physical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms. This REQUIREMENT is not met as evidenced by: Based on record review, observation and interview the facility failed to accurately assess and address a restraint device for one of four residents (R4) reviewed for a waist safety device in the sample of 11. Findings include: 1. The October 2013 Physician's Order Sheet in the medical record for R4 includes an order dated 3-11-13 for a self releasing seat belt. The order includes to release every two hours at meals, activities and when staff available. During the initial tour on 10-27-13 at 9:15 AM, R4 was observed in the dining room in a wheel chair with a seat belt buckled. On 10-28-13 at 9 AM, R4 was observed leaning forward in her wheel chair while wheeling with her feet in the television area of the facility. R4 was wearing a seat belt at this time. The Physical Restraint/Enabler Assessment dated 4-11-13 identifies the use of a personal alarm and a self releasing seat belt. The reasons	F 221		

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

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145759	A. BUILDING _____ B. WING _____	10/30/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROSICLARE REHABILITATION & HCC	FERRELL ROAD, PO BOX 220 ROSICLARE, IL 62982

(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
F 221	Continued From page 1 for use are noted as the diagnosis of Dementia with decreased safety awareness. A Restraint Progress Note dated 10-1-13 documents an alarmed self releasing seat belt being utilized. The Quarterly Minimum Data Set dated 8-19-13 indicates in Section P; no physical restraints. On 10-28-13 at 9:15 AM, E4 (MDS Coordinator) during interview stated, "R4 cannot release the seat belt on her own. R4 could possibly stand on her own, and would not be safe because she ambulates with the assist of two persons".	F 221		
F 246 SS=D	483.15(e)(1) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered. This REQUIREMENT is not met as evidenced by: Based on observation and interviews the facility failed to ensure call lights are answered timely for one of 11 residents (R5) reviewed for timely assistance in the sample of 11, and 3 residents (R13, R14, R15) in the supplemental sample. Findings include: 1. During the Group Interview at 1:30 PM on 10-28-13, two of four residents complained of waiting a long time for staff to answer their call	F 246		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145759	A. BUILDING _____ B. WING _____	10/30/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROSICLARE REHABILITATION & HCC	**FERRELL ROAD, PO BOX 220 ROSICLARE, IL 62982**

(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
F 246	Continued From page 2 lights. R13 stated he needs assistance with transferring from his bed to his wheel chair because of a lower leg amputation. R13 noted he will sometimes wait 1.5 to 2 hours because staff will enter his room, turn off his light, and state they will be back and then not return for a long time. R12 commented she sometimes waits 1.5 hours for staff to answer her call light for assistance to the bathroom. 2. On 10-27-13 the call light was observed on for R14 at 9:05 AM. Surveyor had continuous observation until 9:30 AM at which time the staff entered her room. E5 (Certified Nurse Aide) and E12 (Housekeeper) were observed in the area at the time R14's call light was observed on, and they made no attempt to enter R14's room to answer the call light. 3. On 10-27-13 at 10:55 AM, R5 during interview indicated the staff did not answer her call light timely. She has to wait for them to answer her call light. She has waited for thirty minutes.	F 246		
F 312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on observation, and record review, the facility staff failed to wash/clean thoroughly one	F 312		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145759	A. BUILDING _____ B. WING _____	10/30/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROSICLARE REHABILITATION & HCC	FERRELL ROAD, PO BOX 220 ROSICLARE, IL 62982

(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
F 312	Continued From page 3 of four residents (R6) after an incontinent episode in the sample of 11 observed for being washed/cleaned thoroughly after an incontinent episode. Findings include: 1. On 10-27-13 at 11:40 AM, R6 had an adult diaper on, and had been incontinent of urine. E13 (Certified Nurse Aide) was observed to wash the area between R6's buttocks, while R6 was laying on his right side. R6 was turned onto his back. E13 only washed the penis. E13 did not wash R6's pubic area, buttocks, inner thighs, or scrotum. R6's Minimum Data Set dated 10-14-13 indicates he is totally incontinent of bowel and bladder. R6 is totally dependent on staff for all of his activities of daily living. The facility's policy and procedure (undated) for Perineal Cleansing for Male Residents indicates: #20. Wash pubic area, including upper inner aspect of both thighs as well as the penis and scrotum.	F 312		
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above.	F 329		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145759	A. BUILDING _____ B. WING _____	10/30/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROSICLARE REHABILITATION & HCC	FERRELL ROAD, PO BOX 220 ROSICLARE, IL 62982

(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
F 329	Continued From page 4 Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: Based on record review, and interview the facility failed to justify the use of psychotropic medication for 1 of 4 residents (R8) reviewed for the use of a psychotropic medication in the sample of 11. Findings include: 1. R8 is a 83 year old woman, who was admitted to the facility on February 15, 2012 with diagnoses including Dementia, Depression, and Anxiety according to Physician Order Sheet dated 10/1/2013. Review of R8's record on 10/28/2013 notes R8 is receiving Olanapine (Zyprexa) 2.5 mg/milligrams daily. Review of the facility's documentation titled Tracking for Mood and Behaviors dated October 2013 noted behavior identified as "resistive to care". Behavior Med Monitoring Record dated 8/3/ 2013	F 329		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145759	A. BUILDING _____ B. WING _____	10/30/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROSICLARE REHABILITATION & HCC	**FERRELL ROAD, PO BOX 220 ROSICLARE, IL 62982**

(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
F 329	Continued From page 5 notes "swats at staff", 8/15 and 8/20/2013 "refuses care", 9/10/2013 notes "short with staff during medication", 9/24/2013 "negative thoughts", 9/26/2013 "swat at staff", 9/30/2013 "tearful", 10/2/2013 "refused care", 10/13/2013 "hollered at staff", 10/16/2013 "delusion, children in room". No other behaviors were identified. During an interview on 10/29/2013 with E4 (Care Plan Coordinator), when asked about behaviors and the justification for the use of the Zyprexa, E4 stated "it is for self harming behaviors", when asked for documentation of those behaviors E4 was unable to provide the documentation.	F 329		