STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145619	A. BUILDING _____ B. WING _____	C 12/17/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROSEWOOD CARE CENTER OF GALESBURG	**1250 WEST CARL SANDBURG DRIVE GALESBURG, IL 61401**

(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 Original Investigation of complaint 1526835/IL82168	F 000		
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to address a known safety hazard (a door-closure device) to prevent injury for one of four residents (R1) reviewed for accidents in a sample of four. FINDINGS INCLUDE: The (revised 2/03) facility policy, Incidents/Accidents directs staff, "(The facility) will take every precaution to prevent the occurrence of accidents. An incident may be defined as, but is not limited to falls, resident injuries of known or unknown origin, or any occurrence of an unusual nature that requires investigation. The Nurse will complete an Incident Report which will include a description of the incident. The DON (Director of Nurses) will review and initial the incident report, Bring the incident to the next census meeting to alert department heads and other key personnel of new incident. The Administrator will identify any	F 323		

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

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F 323	Continued From page 1 serious trends or concerns and discuss at the Quality Assurance/Safety meetings. R1's current Physician Order Sheet, dated December 2015 includes the following diagnoses: Malignant Neoplasm with partial resection of right side brain tumor, Epilepsy, Focal onset seizures, Back pain and Chronic pain. R1's current Minimum Data Set (MDS), dated 11/20/15 documents R1 requires the use of a walker as a mobility device. The (Facility) Incident/Accident Report, dated 11/13/15 documents, "Resident stated that (R1) bumped (R1)'s forehead on bathroom door. (R1) complains of pain to forehead." The facility Incident Investigation form, dated 11/13/15 and signed by E2 Director of Nurses documents, "52 year old with diagnosis of Malignant Neoplasm of Parietal Lobe. Lack of coordination." The form also documents, "Etiology of incident determined as due to having auto closure on door. It closed too soon." Also documented under Post Investigation Actions is, "Will monitor at this time." On 12/16/15 at 3:10 P.M., E2 Director of Nurses (DON) stated, "(R1) bumped (R1)'s head on the bathroom door because it has an auto closure on it and it closes too soon. There's nothing we can do about it." On 12/17/15 at 9:40 A.M., R1 stated, "I have hit my head on the bathroom door a couple of times now. It closes too soon. I can't get into the bathroom soon enough with my walker. I guess I'm too slow. They say there isn't anything they	F 323		

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F 323	Continued From page 2 can do about it. I don't even tell them when I hit my head anymore." On 12/17/15 at 9:50 A.M., R1 walked with a walker to the bathroom in (R1)'s room. R1 opened the bathroom door and attempted to turn-around and back into the bathroom. R1's bathroom door immediately began closing and hit R1's walker, jarring R1. On 12/17/15 at 10:00 A.M., E4 Maintenance Director stated, "The bathroom doors are spring-loaded due to the resident room fir door being unable to close if the bathroom door is open. (R1)'s door starts to close immediately. I wish it were slower. It doesn't give a resident too much time to get in the bathroom without the door hitting them. I have never received a maintenance request to fix the auto closure on (R1)'s bathroom door."	F 323		
F 332 SS=D	483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE The facility must ensure that it is free of medication error rates of five percent or greater. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to give medications as ordered by the physician to R2, R3 and R4. This failure resulted in fourteen medication errors out of thirty opportunities for error, for a 47% medication error rate. FINDINGS INCLUDE:	F 332		

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F 332	Continued From page 3 The revised (4-30-2007) facility policy, Medication Administration Guidelines directs staff, "(The facility) will administer medications per a standardized schedule except when the physician's order dictates it be given at another time. Standard medication administration time allows for administration of the medicine within one hour before to one hour after the designated time." 1. On 12/16/15 at 9:13 A.M., E3 Licensed Practical Nurse (LPN) prepared to administer medications to R2 including Omeperazole 20 MG (milligrams) one tablet, Carvedilol 625 MG one tablet, Potassium Chloride 20 MEQ (milliequivalents) one tablet, clonazepam 0.5 mg one tablet, diltiazem 30mg one tab, colace 100mg one capsule, furosemide 40mg one tablet, gabapentin 600mg one tablet and spirolactone 50mg one tablet in a 30 ML (milliliter) plastic medication cup and added applesauce to the cup. R2 took the medication from a spoon that E3 LPN placed in R2's mouth. R2 then drank 30 ML of Prostat. E3 LPN left R2's room, applied alcohol gel to her hands, documented the medication administration and proceeded down the hall. R2's current Physician Order Sheet dated December 2015 includes the following medications: Omeprazole DR 20 MG one capsule by mouth at 7:30 A.M. daily, Carvedilol 6.25 MG give 2 tablets by mouth twice daily at 8:00 A.M. and 4:00 P.M., Clonazepam 0.5 mg one tablet by mouth twice daily at 8am and 8pm, diltiazem 30mg one tablet by mouth three time daily at 8am, 2pm and 6pm, colace 100mg one capsule by mouth twice daily at 8 am and 4pm, furosemide 40mg one tablet by mouth twice daily	F 332		

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F 332	Continued From page 4 at 8am and 4pm, gabapentin 600mg one tablet by mouth three time daily at 8am, 12pm, and 4 pm, Miralax dissolve 1 capful in 4-8 ounces of liquid and give by mouth daily at 8:00 A.M., Potassium Chloride 20 MEQ give 2 tablets by mouth twice daily at 8:00 A.M. and 4:00 P.M., spirolactone 50mg one tablet twice daily at 8 am and 8pm and MultiVitamins with minerals one tablet daily at 8:00 A.M. 2. On 12/16/15 at 9:30 A.M., E3 LPN administered morning medications to R3. E3 LPN did not administer Refresh Plus 0.5% Eye Drops or Liquitears 1.4% Eye Drops to R3. R3's current Physician Order Sheet, dated December 2015 includes the following medications to be administered at 8:00 A.M. : Refresh Plus 0.5% Eye Drops instill one drop into both eyes every two hours and Liquitears 1.4% one drop into both eyes four times daily. 3. On 12/16/15 at 9:35 A.M., E3 LPN administered morning medications to R4. E3 LPN did not administer Probiotic Formula Capsule one tablet or Multivitamins with Minerals one tablet. R4's current Physician Order Sheet, dated December 2015 includes the following medications to be administered at 8:00 A.M.: Probiotic Formula Capsule one capsule daily and Multivitamin with Minerals one tablet daily. On 12/16/15 at 2:00 P.M., E3 LPN stated, "I start my (morning) medication pass around 7:00 A.M. I usually finish around 9:00 A.M. I don't know why I was so late doing medications today. I didn't have any emergencies. (R2) and (R4) didn't get a Multivitamin with Minerals today because I don't	F 332		

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F 332	Continued From page 5 have any in my cart. I didn't realize I only gave (R2) one tablet of Carvedilol and Potassium instead of two. I forgot all about (R2)'s Miralax, (R2) didn't get any this morning. I wasn't sure if I should give (R3)'s eye drops out in the lounge and then I forgot about going back to give them."	F 332		
F 333 SS=D	483.25(m)(2) RESIDENTS FREE OF SIGNIFICANT MED ERRORS The facility must ensure that residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to accurately administer medications as ordered to R1, including chemotherapy medications to treat brain cancer and medications to prevent seizures. This failure resulted in R1 experiencing increased nausea and increased seizures. R1 is one of four residents reviewed for medication administration in a sample of four. FINDINGS INCLUDE: The revised (4-30-2007) facility policy titled Medication Administration Guidelines directs staff, "(The facility) will administer medications per a physician's order, as ordered by the physician." R1's current facility Face Sheet documents that R1 was admitted to the facility on 11/11/15 with the following diagnoses: Malignant Neoplasm with partial resection of right side brain tumor, Epilepsy, Focal onset seizures, Back pain and Benign Prostatic Hypertrophy (BPH).	F 333		

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F 333	Continued From page 6	F 333		

R1's Admission Orders from R1's physician, dated 11/11/15 include the following medications: Trileptal 300 MG (milligrams) take 3 tablets by mouth three times daily for Epilepsy and Focal-onset Seizures and Temador 140 MG take 3 capsules at bedtime (HS) for 5 days, then off for 23 days, to begin on 11/29/15 for Malignant Neoplasm of the brain.

R1's Medication Administration Record (MAR) dated 11/11/15 through 11/30/15 documents R1 received Trileptal 300 MG one tablet at 8:00 A.M. on 11/11/15, one tablet twice daily on 11/12/15 and one tablet at 8:00 A.M. on 11/13/15.

On 12/16/15 at 8:52 A.M., (R1's sibling) Z1 stated, "I took (R1) out to dinner the night of 11/13/15. The facility staff gave me a small white envelope with (R1)'s medications to take. There was only one Trileptal in the envelope. I called the facility and they told me the order on the MAR was written as 'Trileptal 300 MG one tablet twice daily.' (R1) told me (R1) had been having focal seizures for the past two days."

R1's Medication Administration Record dated 11/11/15 through 11/30/15 documents "Temador 420 MG one capsule X 5 days, then off 28 days X 5 cycles. Last dose 11/6/15, next cycle start 12/4/15." The same MAR documents facility staff administered one capsule of Temador 120 MG on 11/30/15 and 12/1/15, instead of three capsules.

On 12/16/15 at 8:52 A.M., (R1's sibling) Z1 stated, "I was in the facility on 12/2/15 and because of all the other medication errors the facility had made, I asked them to count (R1)'s chemo (chemotherapy) drug (Temador) with me.

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F 333	Continued From page 7 There were too many pills left in the bottle. They had only been giving (R1) one pill instead of three. The nurse called the Cancer doctor and (R1) had to take additional pills for 3 days to make up for the mistake. Of course, (R1) had more nausea during that time." On 12/16/15 at 3:10 P.M., E2 Director of Nurses (DON) stated, "We made some mistakes when (R1) was first admitted with (R1)'s medications. They were complicated. (R1) missed a few doses of Temador and Trileptal." On 12/23/15 at 9:20 A.M., Z3 Oncologist stated, "Temador is an oral chemotherapy drug. It is precisely prescribed using a dose based on a patient's height and weight. Temador is important to take precisely as prescribed. The purpose of Temador is to increase a patient's life expectancy by six months. I received the phone call from the patient's sister on December second that the facility had been giving (R1) the wrong dose of medication. (R1) only received one capsule instead of three capsules on 11/30/15 and 12/1/15. Because of the error, we had to increase (R1)'s dosage to four capsules on 12/2/15, 12/3/15 and 12/4/15. This increased dosage will cause increased nausea in a patient. (R1) never did complete the correct cycle of Temador on 12/4/15, as there was one pill left over from that cycle."	F 333		
F 425 SS=D	483.60(a),(b) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit	F 425		

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F 425	Continued From page 8 unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to obtain medications ordered for two of three residents (R2 and R4) reviewed for medication administration in a sample of four. FINDINGS INCLUDE: The facility policy, Medication Ordering, dated 09/10 directs staff, "Medications and related products are received from the provider pharmacy on a timely basis. Reorder routine medications by the re-order date on the label to assure an adequate supply is on hand." 1. On 12/16/15 at 9:13 A.M., E3 Licensed Practical Nurse (LPN) administered morning medications to R2. Multivitamins with minerals and Miralax were not included.	F 425		

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F 425	Continued From page 9 R2's current Physician Order Sheet dated December 2015 includes the following medications: Miralax dissolve 1 capful in 4-8 ounces of liquid and give by mouth daily at 8:00 A.M. and MultiVitamins with minerals one tablet daily at 8:00 A.M. 2. On 12/16/15 at 9:35 A.M., E3 LPN administered medications to R4. Probiotic and Multivitamins with minerals were not included. R4's current Physician Order Sheet, dated December 2015 includes the following medications to be administered at 8:00 A.M.: Probiotic Formula Capsule one capsule and Multivitamin with Minerals one tablet. On 12/16/15 at 2:00 P.M., E3 LPN stated, "I start my (morning) medication pass around 7:00 A.M. I usually finish around 9:00 A.M. I don't know why I was so late doing medications today. I didn't have any emergencies. (R2) and (R4) didn't get a Multivitamin with Minerals today because I don't have any in my cart." On 12/16/15 at 3:10 P.M., E2 Director of Nurses (DON) stated, " (Nursing) staff are supposed to pull the (medication reorder) sticker at least one week in advance and fax it to the pharmacy. The pharmacy then delivers it the next day. We also have an Emergency box and a Convience box with meds (medications) in them. They can also call the pharmacy and the pharmacy will call (the local) back-up pharmacy and they will deliver medications. That way we are never out of medications. Resident's medications are supposed to be given as ordered by the physician. A nurse should never omit a dose or	F 425		

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F 425	Continued From page 10 not give a medication."	F 425		
F 514 SS=D	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to accuratley transcribe physician orders for one of four residents (R1) reviewed for accuracy of medical records in a sample of four. FINDINGS INCLUDE: The revised (3-15-2013) facility policy, Physician Orders, directs staff, "The prescriber's orders must be documented completely in the medical record." R1's current facility Face Sheet documents that R1 was admitted to the facility on 11/11/15 with the following diagnoses: Malignant Neoplasm with partial resection of right side brain tumor, Epilepsy, Focal onset seizures, Back pain and	F 514		

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F 514	Continued From page 11 Benign Prostatic Hypertrophy (BPH). R1's Admission Orders from R1's physician, dated 11/11/15 include the following medications: Trileptal 300 MG (milligrams) take 3 tablets by mouth three times daily for Epilepsy and Focal-onset Seizures and Temador 140 MG take three tablets by mouth at bedtime (HS) for 5 nights. Off 23 days, on 5 days. R1's Medication Administration Report dated 11/11/13 documents, "Trileptal 300 MG take one tablet by mouth two times daily. And Temador 420 MG take one tablet for 5 days, then off 28 days for 5 cycles."	F 514		