DEPART	MENT OF HEALTH AN	ID HUMAN SERVICES				RM APPROVED
CENTER	S FOR MEDICARE &	MEDICAID SERVICES			OMB I	NO. 0938-0391
-	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /	IPLE CONSTRUCTION	. ,	TE SURVEY MPLETED
		145680	B. WING _			C)4/19/2016
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STAT	FE, ZIP CODE	
ROSEWO	OD CARE CENTER OF N	IOLINE				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECT CROSS-REFERENC	PLAN OF CORRECTION TVE ACTION SHOULD BE CED TO THE APPROPRIATE SFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS		FO	00		
F 155 SS=G	Original investigation #1621969/IL84742 483.10(b)(4) RIGHT ADVANCE DIRECTIV	TO REFUSE; FORMULATE	F 1	55		
	The facility must comply with the requirements specified in subpart I of part 489 of this chapter related to maintaining written policies and procedures regarding advance directives. These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the individual's option, formulate an advance directive. This includes a written description of the facility's policies to implement advance directives and applicable State law.					
	by: Based on interview a failed to follow the ad cardio-pulmonary res (R1) of three reviewer sample of six. This fa not performing cardio R1, contrary to R1 ' s	is not met as evidenced and record review, the facility vance directives regarding uscitation for one resident d for advance directives in a ilure resulted in facility staff -pulmonary resuscitation on advance directive to be mented in the resident 's				

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

PRINTED: 04/22/2016

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.

	-	ID HUMAN SERVICES MEDICAID SERVICES					FORM): 04/22/2016 1 APPROVED). 0938-0391
STATEMENT (OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	• •		ONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		145680	B. WING					C 19/2016
NAME OF P	ROVIDER OR SUPPLIER			STR	EET ADDRESS, CITY, STATE, ZIP COL)E		
ROSEWO	OD CARE CENTER OF M	IOLINE			0 34TH AVENUE LINE, IL 61265			
(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 CO (EACH CORRECTIVE ACTIO) CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIAT	E	(X5) COMPLETION DATE
F 155	medical record. R1 t	hen expired in the facility.	F 1	55				
	The facility policy entitled "Code Status", revised I/2016, documents,"(The facilty) will honor code status preferences as documented by the esident or their legally authorized epresentativeA physician's order will be obtained by the nurse, based on code status preference indicated by the resident, legally authorized Health Care Power of Attorney (POA),							
	or legally authorized the absence of a valid order (including wher has been made or co determined), CPR (ca	Health Care SurrogateIn d Do Not Resuscitate (DNR) n no code status decision de status cannot be						
	R1 was readmitted to R1's Physician Order	eet, dated 4/8/16 documents the facility on 4/8/16. Sheet, dated 4/8/16 physician orders, "Advance						
	Life-Sustaining Treat 4/8/16 documents, "C Resuscitation; If patie	tate/Practitioner Orders For ment (POLST) Form dated Cardiopulmonary ent has no pulse and is not suscitation/CPR" and is						
	signed by R1's sister Decision Maker).	(Health Care Surrogate Progress Notes, dated						
	Code (current status) request for Full Code CPR and call 911."	d 4/8/16 documents, "Full . Will honor residents . If cardiac arrest, initiate						
		dated 4/13/16 at 7:50 A.M. 1) to be sleeping, no S/S						

Facility ID: IL6012587

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	-	ID HUMAN SERVICES MEDICAID SERVICES			FOR	ED: 04/22/2016 RM APPROVED O. 0938-0391
STATEMENT	STATEMENT OF DEFICIENCIES (X1) PROVIDER/ AND PLAN OF CORRECTION IDENTIFICAT		. ,	E CONSTRUCTION	(X3) DAT	E SURVEY IPLETED
		145680	B. WING		04	C 4/19/2016
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COE		
POSEWO	OD CARE CENTER OF M			7300 34TH AVENUE		
RUSEWU	OD CARE CENTER OF W	IGLINE		MOLINE, IL 61265		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
F 155	document, "CNA (cer approached writer an (R1)'s room. Writer in and found (R1) with (BP (blood pressure), (and) mottling noted. absence of vital signs cyanosis noted aroun extremities, warm to g R1's Nurse's Notes, of document, (E9) Regis and also found (R1) (pulse. Writer, ADON Nurses) returned to ro (DON) (E2/Director o all agreed absence or mottling and rigor mo R1's Nurse's Notes, of document, "(R1) pror The facility form, Incid 4/13/16 documents, " Upon initial exam it w by multiple nurses tha of life, no vital signs, mortis was noted. CP to) prior." E11/Assistant Director Investigation statement documents, "I was sitt Nurses) office when (inform (E2/DON) that (R1)'s room in bed. (B (E2/DON). (E11/ADO) where CNA's were per cares(R1) was left for On 4/19/16 at 10:08 /	discomfort." dated 4/13/16 at 9:15 A.M. tified nursing assistant) d asked for writer to come to mediately went to room no) apical/radial pulse, (no) blue nail beds, rigor mortis CPR not initiated d/t (due to) s, pulse, respiration, id mouth. Body was cold at groin." dated 4/13/16 at 9:20 A.M. stered Nurse assessed (R1) with) (no) B/P, respirations, (Assistant Director of com for further assessment. f Nurses) entered room and f vital signs, cyanosis, rtis present." dated 4/13/16 at 9:35 A.M. nounced dead." dent Investigation, dated Res (resident) expired. vas identified and confirmed at the resident had no signs (R1) was mottled and rigor 'R not initiated R/To (related or of Nurses Incident ent, dated 4/13/16 ting in the DON (Director of (E6/LPN) nurse called to . (R1) was unresponsive in	F 15	5		

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		ID HUMAN SERVICES MEDICAID SERVICES				FOR	D: 04/22/2016 MAPPROVED O. 0938-0391		
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		CONSTRUCTION	(X3) DAT	E SURVEY IPLETED		
		145680	B. WING			C 04/19/2016			
NAME OF P	ROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE				
POSEWO	OD CARE CENTER OF M			73	00 34TH AVENUE				
ROSEWO	OD CARE CENTER OF IN			M	OLINE, IL 61265				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE		
F 155	cleaned (R1) up abou (R1)'s eyes were ope (R1)'s eyes yes or no About 9:00 o'clock , (room) and came out it think (R1) passed.' I g checked for a heart b anything. So I sent (E (R1)'s fingers were bl not see the nurses do should (start CPR) or On 4/19/16 at 11:10 A Nurse (LPN) stated, " (R1) a scheduled bre A.M. I noticed (R1) w 650 MG (milligrams) to the breakfast room CNA came and got m wrong with (R1). (R1) stethoscope, I checke no pulse, no blood pr was cyanotic and mo (R1)'s chart and saw (E2/Director of Nurse (E2)'s office. The ADO Nurses) (E11) came o and then (E2) DON c The group of us decid was too far gone. (R1 (R1)'s extremities we going on (R1), in (R1 Power of Attorney), (f in shock. (R1's Powe (R1's death). I know o from when (R1) was f pronounced (R1) dea not perform CPR on (On 4/19/16 at 1:00 P.	att 8:00 O'clock (A.M.) . n and (R1) was blinking (answering questions). E10/CNA) went in (R1's in the hallway and said, 'I got a stethoscope and eat and I couldn't hear E10/CNA) to get the nurse. ue. I did not start CPR. I did o CPR. I wasn't sure if I not." A.M., E6/Licensed Practical 'On the thirteenth, I gave athing treatment before 8:00 as grimacing, so I gave (R1) of Tylenol (for pain). I went from 8:00 until 9:10. (E10) the and said something is) was gray. I had a ed (R1)'s pulse. (There) was essure, no respirations. (R1) ttled. I immediately went to (R1) was a full code. I called s). (E2/DON) wasn't in DN (Assistant Director of down and assessed (R1). ame and assessed (R1). ded not to start CPR, (R1) I)'s groin was still warm, re cool. (R1) did have a fan I)'s room. I called (R1''s R1's Power of Attorney) was r of Attorney) didn't expect it quite a bit of time passed, found and until we d. (R1) was a full code. I did	F	155					

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM): 04/22/2016 MAPPROVED). 0938-0391
STATEMENT O	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,	PLE CONSTRUCTION	_	(X3) DATE SURVEY COMPLETED C	
		145680	B. WING				19/2016
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY,	STATE, ZIP CODE		
ROSEWO	OD CARE CENTER OF M	IOLINE		7300 34TH AVENUE MOLINE, IL 61265			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORR	R'S PLAN OF CORRECTION RECTIVE ACTION SHOULD BI RENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 155 F 157 SS=D	reviewing (R1)'s medi previous hospitalization months ago and suffer complicationsWhen (R1)''s passing, I asked instituted advance lifer repeatedly (E6/LPN) of mortis already setting two to four hours after On 4/19/16 at 2:55 P. stated, "I did an invest because it was so biz here a short timeTh not to do CPR and the 483.10(b)(11) NOTIFY (INJURY/DECLINE/R A facility must immedi consult with the resider known, notify the resider known, notify the resider or an interested family accident involving the injury and has the poter intervention; a significe physical, mental, or p deterioration in health status in either life the clinical complications significantly (i.e., a ne existing form of treatm consequences, or to of treatment); or a deciss the resident from the §483.12(a). The facility must also	spent a great deal of time ical record from (R1)"s ons. (R1) had surgery a few red many set backs and (E6/LPN) called me about ed (E6/LPN) if (E6/LPN) e support. (E6/LPN) told me did not (do CPR) due to rigor in. Rigor mortis sets in , in r death, but it is variable." M., E2/ Director of Nurses tigation (into R1's death), arre. (R1) had only been e nurses made the decision e doctor had been called." Y OF CHANGES OOM, ETC) iately inform the resident; ent's physician; and if dent's legal representative y member when there is an e resident which results in ential for requiring physician cant change in the resident's sychosocial status (i.e., a a, mental, or psychosocial eatening conditions or); a need to alter treatment end due to adverse commence a new form of ion to transfer or discharge facility as specified in	F 15				
	deterioration in health status in either life thr clinical complications significantly (i.e., a ne existing form of treatm consequences, or to o treatment); or a decis the resident from the §483.12(a). The facility must also	a, mental, or psychosocial eatening conditions or); a need to alter treatment ed to discontinue an nent due to adverse commence a new form of ion to transfer or discharge facility as specified in					

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE COMF	
		145680	B. WING			04/	19/2016
NAME OF P	ROVIDER OR SUPPLIER		·	S	TREET ADDRESS, CITY, STATE, ZIP CODE	-	
ROSEWO	OD CARE CENTER OF N	IOLINE			300 34TH AVENUE IOLINE, IL 61265		
(X4) ID PREFIX TAG	(EACH DEFICIENC	SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION CH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE JLATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) DEFICIENCY)					(X5) COMPLETION DATE
F 157	or interested family m change in room or roo specified in §483.15(resident rights under regulations as specific this section. The facility must reco the address and phor legal representative of This REQUIREMENT by: Based on interview a failed to notify the phy resident's condition for (R1) reviewed for phy sample of six. FINDINGS INCLUDE The facility policy, Re in Resident's Condition staff, "Each charge nu assessing the resider basis. The charge nu of any significant char condition at the time to R1's current Physicia 2016 includes the foll Pneumonia, Respirate Esophageal Perforation Diaphragmatic Hernia Abdominal Abscesses Cerebral Palsy.	 aember when there is a commate assignment as (e)(2); or a change in Federal or State law or ed in paragraph (b)(1) of rd and periodically update the number of the resident's or interested family member. is not met as evidenced and record review, the facility ysician of a change in a three residents residents resident and three resident's three change is noted." n Order Sheet, dated April owing diagnoses: Sepsis, ory Failure, Status Post 	F	157			

Facility ID: IL6012587

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	-	ID HUMAN SERVICES MEDICAID SERVICES			PRINTED: 04/22/2016 FORM APPROVED OMB NO. 0938-0391		
STATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		145680	B. WING		C 04/19/2016		
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE			
ROSEWO	OD CARE CENTER OF N	IOLINE		7300 34TH AVENUE MOLINE, IL 61265			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE COMPLETION		
F 157	looks at nurse. Alert, (R1) was asked if in a blinked twice. (R1) was (temperature) was tak Tylenol 650 MG (millin needed) via J (jejunos (R1) repositioned ever feeding present and c monitor." R1's Vital Sign Flow S Temperature as 97.9, 4/8/16 and 4/9/16. On 4/19/16 at 9:50 A. Nurse (LPN) stated, " (certified nursing assi (R1) was feeling warr (R1) was feeling warr (R1) was feeling warr (R1) was sweaty. (R1 and (R1)'s hair was w 101.8 (degrees). I gav called the doctor about to leave a voice mail. tell (the doctor)." On 4/19/16 at 12:50 F verified that a nurse is change in a resident's elevated temperature 483.25(c) TREATMEN PREVENT/HEAL PRI Based on the compre- resident, the facility m who enters the facility m who enters the facility m	asked if in any pain, (R1) but does not say anything. any pain, blink twice. (R1) arm to touch. Temp ken and it is 101.8 degrees. grams) given PRN (as stomy) tube. No complaints. ary two hours. Continuous boxygen. Will continue to Sheet documents R1's 98.1, 97.1 and 97.4 on M., E4/Licensed Practical (On 4/10/16) a CNA stant) came to me and said n. When I went to the room,) had sweat on (R1)'s face vet. (R1)'s temperature was ve (R1) some tylenol. I ut something else, but I had So I didn't get a chance to P.M., E2/Director of Nurses s to call the physician with a s condition, including an NT/SVCS TO	F 15				

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	-	D HUMAN SERVICES				FORM	04/22/2016 APPROVED	
STATEMENT O	DF DEFICIENCIES CORRECTION	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	CONSTRUCTION		OMB NO. 0938-039 (X3) DATE SURVEY COMPLETED		
		145680	B. WING		C 04/19/2016			
NAME OF PI	ROVIDER OR SUPPLIER		s	TREET ADDRESS, CITY, STATE	E, ZIP CODE			
ROSEWO	OD CARE CENTER OF M	OLINE		300 34TH AVENUE IOLINE, IL 61265				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIN CROSS-REFERENCE	AN OF CORRECTION VE ACTION SHOULD BE ED TO THE APPROPRIA ICIENCY)		(X5) COMPLETION DATE	
F 314	pressure sores receiv services to promote h prevent new sores fro This REQUIREMENT by: Based on observation review, the facility fail pressure ulcer and fail care to prevent contain pressure ulcer for one reviewed for pressure FINDINGS INCLUDE On 4/18/16 at 1:05 P. Nursing Assistants (C Rehab/Restorative Aid from the wheel chair to After transferring R3, removed R3 pants an There was a large arm brief. A 2 CM (centime deep pressure ulcer var the pressure ulcer var white macerated area dressing was in place a disposable wipe, E3 buttocks, including the the wound with the so E12/CNAs then appli incontinence brief on	e; and a resident having es necessary treatment and ealing, prevent infection and im developing. is not met as evidenced in, interview and record ed to cover a stage two ided to perform incontinence mination of a stage two e of three residents (R3) ulcers in a sample of six. M., E3 and E12 Certified NAs) and E13 d prepared to transfer R3 o bed via a mechanical lift. E3 and E12/CNAs, d adult incontinence brief. iount of brown stool in the teter) X 1 CM X 0.4 CM vas present to R3's coccyx. ad a pink wound bed with a surrounding the wound. No , covering the wound. Using B/CNA cleaned R3's e pressure ulcer. Wiping biled cloth. E3 and ed a clean disposable	F 314					
		Risk Assessment, dated is at High Risk for the						

Facility ID: IL6012587

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-					FORM	M APPROVED 0. 0938-0391		
OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l` í			(X3) DATE COMF			
	145680	B. WING			04/19/2016			
ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>			
OD CARE CENTER OF M	IOLINE							
(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL			(EACH CORRECTIVE ACTION SHOULD	BE	(X5) COMPLETION DATE		
development of press R3's current Care Pla "Problems: Stage 2 C Interventions: Assess signs and symptoms of treatment as ordered. Administration Record area." R3's current Physicial 2016 includes the foll Cleanse wound to sad Saline, apply Wound (non-adherent dressin On 4/18/16 at 1:15 P. mean to wipe over (R (disposable wipe). I d have a dressing on (F up this morning." On 4/18/16 at 1:25 P. Assistant (CNA) state This is my first time w got (R3) up before 8:0 (R3) having a dressin got (R3) up. Nobody t ulcer." On 4/19/16 at 12:50 F confirmed (R3) should (R3)'s coccyx at all tir a pressure ulcer wound	 n, dated 3/6/16 documents, Eoccyx Wound. wound weekly. Monitor for of infection. Provide See Treatment d. Use caution to protect n Order Sheet, dated April owing treatment orders: cral area with Normal Gel. Cover with hg) and tape. M., E3/CNA stated, "I didn't 3)'s bed sore with it on't know why (R3) didn't R3)'s wound. I didn't get (R3) M., Z1/Certified Nursing d, "I am an Agency CNA. orking here (the facility). I 20 A.M. I don't remember g on (R3's coccyx) when we cold me (R3) had a pressure P.M., E2/Director of Nurses d have a dressing in place to me. E2/DON also confirmed nd should not be cleaned 	F	314					
	S FOR MEDICARE & I DF DEFICIENCIES CORRECTION ROVIDER OR SUPPLIER OD CARE CENTER OF M SUMMARY STI (EACH DEFICIENCY REGULATORY OR L Continued From page development of press R3's current Care Pla "Problems: Stage 2 C Interventions: Assess signs and symptoms of treatment as ordered. Administration Record area." R3's current Physician 2016 includes the follo Cleanse wound to sate Saline, apply Wound (non-adherent dressin On 4/18/16 at 1:15 P. mean to wipe over (R (disposable wipe). I d have a dressing on (F up this morning." On 4/18/16 at 1:25 P. Assistant (CNA) state This is my first time w got (R3) up before 8:0 (R3) having a dressin got (R3) up. Nobody function ulcer." On 4/19/16 at 12:50 F confirmed (R3) should (R3)'s coccyx at all tir a pressure ulcer wour with a soiled, disposa requests, E2/DON dic	CORRECTION IDENTIFICATION NUMBER: 145680 ROVIDER OD CARE CENTER OF MOLINE SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 8 development of pressure ulcers. R3's current Care Plan, dated 3/6/16 documents, "Problems: Stage 2 Coccyx Wound. Interventions: Assess wound weekly. Monitor for signs and symptoms of infection. Provide treatment as ordered. See Treatment Administration Record. Use caution to protect area." R3's current Physician Order Sheet, dated April 2016 includes the following treatment orders: Cleanse wound to sacral area with Normal Saline, apply Wound Gel. Cover with (non-adherent dressing) and tape. On 4/18/16 at 1:15 P.M., E3/CNA stated, "I didn't mean to wipe over (R3)'s bed sore with it (disposable wipe). I don't know why (R3) didn't have a dressing on (R3)'s wound. I didn't get (R3) up this morning." On 4/18/16 at 1:25 P.M., Z1/Certified Nursing Assistant (CNA) stated, "I am an Agency CNA. This is my first time working here (the facility). I got (R3) up before 8:00 A.M. I don't remember (R3) having a dressing on (R3's coccyx) when we got (R3) up. Nobody told me (R3) had a pressure ulcer." On 4/19/16 at 12:50 P.M., E2/Director of Nurses confirmed (R3) should have a dressing in place to (R3)'s coccyx at all time. E2/DON also confirmed a pressure ulcer wound should not be cleaned with a soiled, disposable wipe. Despite repeated requests, E2/DON did not provide a policy for wound cleansing or application of a wound	ES FOR MEDICARE & MEDICAID SERVICES OP DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MUL A. BUILD 145680 B. WING ROVIDER OR SUPPLIER IDENTIFICATION NUMBER: (X2) MUL A. BUILD SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID PREF TAG Continued From page 8 F development of pressure ulcers. F R3's current Care Plan, dated 3/6/16 documents, "Problems: Stage 2 Coccyx Wound. Interventions: Assess wound weekly. Monitor for signs and symptoms of infection. Provide treatment as ordered. See Treatment Administration Record. Use caution to protect area." R3's current Physician Order Sheet, dated April 2016 includes the following treatment orders: Cleanse wound to sacral area with Normal Saline, apply Wound Gel. Cover with (non-adherent dressing) and tape. On 4/18/16 at 1:15 P.M., E3/CNA stated, "I didn't mean to wipe over (R3)'s bed sore with it (disposable wipe). I don't know why (R3) didn't have a dressing on (R3's coccyx) when we got (R3) up before 8:00 A.M. I don't get (R3) up this morning." On 4/18/16 at 1:25 P.M., Z1/Certified Nursing Assistant (CNA) stated, "I am an Agency CNA. This is my first time working here (the facility). I got (R3) up. Nobody told me (R3) had a pressure ulcer." On 4/19/16 at 12:50 P.M., E2/Director of Nurses confirmed (R3) should have a dressing in place to (R3)'s coccyx at all time. E2/DON also confirmed a pressure ulcer wound should not b cleaned with a soiled, disposable wipe. Des	ES FOR MEDICARE & MEDICAID SERVICES OP DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPL A. BUILDING 145680 B. WING ROVIDER OR SUPPLIER ID OD CARE CENTER OF MOLINE ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID ROVIDER Continued From page 8 F 314 development of pressure ulcers. R3's current Care Plan, dated 3/6/16 documents, "Problems: Stage 2 Coccyx Wound. Interventions: Assess wound weekly. Monitor for signs and symptoms of infection. Provide treatment as ordered. See Treatment Administration Record. Use caution to protect area." R3's current Physician Order Sheet, dated April 2016 includes the following treatment orders: Cleanse wound to sacral area with Normal Saline, apply Wound Gel. Cover with (non-adherent dressing) and tape. On 4/18/16 at 1:15 P.M., E3/CNA stated, "I didn't mean to wipe over (R3)'s bed sore with it (disposable wipe). I don't know why (R3) didn't have a dressing on (R3)'s wound. I didn't get (R3) up this morning." On 4/18/16 at 1:25 P.M., Z1/Certified Nursing Assistant (CNA) stated, "I am an Agency CNA. This is my first time working here (the facility). I got (R3) up before 8:00 A.M. I don't remember (R3) having a dressing on (R3's coccyx) when we got (R3) having a dressing on (R3's coccyx) when we got (R3) having a dressing on (R3's coccyx) when we got (R3) having a dressing on (R3's coccyx) when we got (R3) having a dressing on (R3's coccyx) when we got (R3) having a dressing on (R3's coccyx) when we got (R3) having a dressing on (R3's co	SFOR MEDICARE & MEDICAID SERVICES OF DEFICIENCES (X1) PROVIDERSUPPLIENCULA DERITINGATION NUMBER: (X2) MULTIPLE CONSTRUCTION A BUILDING 145680 STREET ADDRESS, CITY, STATE, ZIP CODE 700 34TH AVENUE MOLINE IN STREET ADDRESS, CITY, STATE, ZIP CODE 700 34TH AVENUE MOLINE, IL \$1285 OD CARE CENTER OF MOLINE ID REQUINTORY OR LSC IDENTIFYING INFORMATION) REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 8 development of pressure ulcers. F 314 R3's current Care Plan, dated 3/6/16 documents, "Problems: Stage 2 Coccyx Wound. Interventions: Assess wound weekly, Monitor for signs and symptoms of infection. Provide treatment as ordered. See Treatment Administration Record. Use caution to protect area." F 314 R3's current Physician Order Sheet, dated April 2016 includes the following treatment orders: Cleanse wound to sacral area with Normal Saline, apply Wound Gel. Cover with (in disposable wipe). I don't know why (R3) didn't have a dressing on (R3)'s wound. I didn't get (R3) up this morning." Naving Aressing on (R3)'s wound. I didn't get (R3) up this morning." On 4/18/16 at 1:25 P.M., 21/Certified Nursing Assistant (CNA) stated, "I am an Agency CNA. This is my first time working here (the facility). I got (R3) wound a dressing on (R3's coccyx) when we got (R3) up Nobody told me (R3) had a pressure ulcer." Naving a dressing on (R3's coccyx) when we got (R3) up. Nobody told me (R3) had a pressure ulcer."	MENT OF HEALTH AND HUMAN SERVICES OMB NG SFOR MEDICARE & MEDICAD SERVICES OMB NG PERCENCIES ON A BULLINE CORRECTION LINE AND THE ADDRESS OF THE ADDRESS O		

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMF	
		145680	B. WING				_ 19/2016
NAME OF PI	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
ROSEWO	OD CARE CENTER OF M	IOLINE			7300 34TH AVENUE MOLINE, IL 61265		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 425 F 425 SS=D	483.60(a),(b) PHARM ACCURATE PROCEI The facility must provid drugs and biologicals them under an agreer §483.75(h) of this par unlicensed personnel law permits, but only us supervision of a licens A facility must provide (including procedures acquiring, receiving, c administering of all dr	ACEUTICAL SVC - DURES, RPH ide routine and emergency to its residents, or obtain ment described in t. The facility may permit to administer drugs if State under the general sed nurse. e pharmaceutical services that assure the accurate dispensing, and rugs and biologicals) to meet		425			
	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.						
	by: Based on interview a failed to provide a phy	is not met as evidenced ind record review, the facility ysician-ordered medication ee residents (R1) reviewed of six.					
	FINDINGS INCLUDE	:					
	Telephone Orders: Fo	irects staff, " Section 111. or orders given by the e over the telephone, the					

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391	
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		E CONSTRUCTION		PLETED	
		145680	B. WING			C 04/19/2016		
NAME OF P	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE			
ROSEWO	OD CARE CENTER OF N	IOLINE			7300 34TH AVENUE MOLINE, IL 61265			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			X	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPR DEFICIENCY)		(X5) COMPLETION DATE	
F 425	prescriber to ensure a Write the order onto t include date and time Transcribe the order of order sheet) in proper order. Record the me the MAR (medication TAR (treatment admin the orders as appropri- R1's Physician Order includes the following Pneumonia, Respirate Esophageal Perforatio Diaphragmatic Hernia Abdominal Abscesses Cerebral Palsy. Also order: Hydrocodone 7 per 15 ML (milliliters). J-Tube (jejunostomy f scheduled at 6:00 A.M. R1's Nurse's Notes da documents, "(R1) cry when asked about pa needed) Tylenol per d and stating resident is pain'. Immediate call Physician) with report received/noted for Hy MG per 15 ML, to rec six hours scheduled a Family, including (R1' pharmacy, she is goin phone to obtain emer	accurate understanding. he Telephone Order form; order was received. boto the POS (physician format, noting a telephone dication or treatment onto administration record) or histration record). Carry out fate." Sheet, dated April 2016 diagnoses: Sepsis, ory Failure, Status Post on during repair of a and Cholecystectomy with s and Mediastinal Abscess, included is the following 7.5 MG (milligrams)/325 MG To receive 10 ML per tube) every 6 hours M., 12:00 P.M., 6:00 P.M. ated 4/12/16 at 1:30 P.M. in. Medicated with PRN (as J-Tube. Family at bedside s definitely having 'a lot of placed to Z2 (R1's to f the above. New orders drocodone Elixir 7.5/325 eive 10 ML per J-Tube every at 6 AM-12 PM-6 PM-12 AM. s sister) aware. Spoke with ng to call (Z2) on (Z2)'s cell	F	425				

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM): 04/22/2016 APPROVED 0. 0938-0391
STATEMENT (OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		145680	B. WING		_	(04/'	C 19/2016
NAME OF P	ROVIDER OR SUPPLIER		S	TREET ADDRESS, CITY, ST	ATE, ZIP CODE	•	10/2010
ROSEWO	OD CARE CENTER OF M		73	300 34TH AVENUE			
			N	IOLINE, IL 61265			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORREC CROSS-REFEREN	BELAN OF CORRECTION CTIVE ACTION SHOULD BE NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 425	"Hydrocodone Elixir 7 receive 10 ML per J-T staff initials are noted medication on 4/12/16 A.M. on 4/13/16. On 4/19/16 at 11:10 A Nurse (LPN) stated, " liquid (On 4/12/16). (2 phone number on the them (Pharmacy) call emergency supply (of the doctor. The medic at 2:15 P.M. The next medicine was not her They said they misse the doctor, but they w pharmacist then calle doctor had changed if PRN (as needed). I h before) to 'Stat it' (em local pharmacy), but t that. The medicine ne doctor) on (April) twel wanted me to call for what (R1) had been m the hospital before (R On 4/19/16 at 12:50 F (DON) stated, "There to follow when a doct medication. If a medic	7.5/325 MG per 15 ML. To Tube every six hours." No It to indicate R1 received this 6 at 6:00 P.M. or at 12:00 A.M., E6/Licensed Practical (Z2) ordered Hyrocodone Z2) said to put (Z2)'s cell a telephone order and have I (Z2). You can get an f medication) if they talk to cine was not here when I left t day I came in (4/13/16) the re, so I called the pharmacy. d the phone number to call yould call right away. The ed me back and said the t (Hydrocodone liquid) to ad asked them (the day hergency) it to me from (a they said they couldn't do ever came in. (I called the lfth because (R1's family) scheduled Morphine. That is receiving around the clock at R1) got here." P.M., E2/Director of Nurses is a (facility) policy for staff	F 425				

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