

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  145818	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  05/22/2024
NAME OF PROVIDER OR SUPPLIER  Rock River Health Care		STREET ADDRESS, CITY, STATE, ZIP CODE 707 West Riverside Boulevard Rockford, IL 61103	

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)
<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.</p> <p>40085</p> <p>Based on observation, interview and record review the facility failed to ensure medications were reconciled for 4 of 4 residents (R2, R3, R4 and R5) reviewed for pharmacy services in the sample of 17.</p> <p>The findings include:</p> <p>On 5/21/24 at 9:40 AM, inside the medication room on the second floor sitting in a box were 20, 2nd floor residents' individual packages of various medications. The dates on these medications were for 5/12/24 at time to be given listed as BED. V6 (Licensed Practical Nurse/LPN) was inside the medication room with the surveyor and said those medications should have been given on 5/12/24 at bedtime. V6 said she has found medications still inside the cart when she comes on duty the next morning that should have been given the evening prior.</p> <p>An individual packet of medication for R2 was one of the 20 resident medications still inside the medication which was Levetiracetam (seizure prevention medication).</p> <p>R2's Medication Administration Record shows the following medications were not signed off as given on 5/12/24 Depakote 500 Milligrams (MG.) to be given in EVE, Flomax 0.4 MG. to be given in EVE, Gabapentin 300 MG. to be given at BED, Levetiracetam 750 MG to be given at BED, Melatonin 5 MG. to be given at BED, Phenytoin Sodium 100 MG 1 capsule to be given in EVE and BED (seizure prevention medication), Pepcid 1 tablet to be given at BED, and Xarelto 20 MG to be given at EVE.</p> <p>On 5/21/24 at 11:35 AM, R2 said he has had issues where he is not getting all of his medications. R2 said he has concerns because some of those medications are seizure medications, and he needs them. He said he has started to write down the dates when this happens but was unable to find the date of 5/12/24 written on any of his papers.</p> <p>R3's medications dated 5/12/24 that were still in the medication room and were listed to be given at BED include Trazadone 50 MG, Atorvastatin 20 MG QD, and Levetiracetam 750 MG. R3's MAR shows those medications were not signed off as given on 5/12/24 at bedtime. In addition, other medications were not initialed as given for that day including Melatonin 10 MG to be given at BED, Glipizide 10 MG, and Metformin 500 both to be given EVE.</p> <p>(continued on next page)</p>

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
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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On 5/21/24 at 11:55 AM, R3 said she was unable to recall any times she had not gotten all her meds. She said, thinks she gets them.</p> <p>R4's medications dated 5/12/24 that were still in the medication room and listed to be given at BED include Eliquis (Apixaban) 5 MG, and Trazadone 100 MG. Neither of those medications were signed off as given in R4's MAR. In addition to those medications other medications not signed off as given on 5/12/24 include: Clonazepam 0.5 MG to be given at BED, Quetiapine 150 MG to be given EVE, Levetiracetam 500 MG to be given EVE, Metoprolol 12.5 MG to be given EVE.</p> <p>On 5/21/24 at 11:30 AM, R4 was unable to recall what medications she takes and just said yes when asked if she receives them. R4's 2/21/24 Minimum Data Set shows she has a mild cognitive deficit.</p> <p>R5's medications dated 5/12/24 that were still in the medication room and listed to be given at BED include Rosuvastatin Calcium 20 MG and Glipizide 10 MG. Neither of those medications were signed off as given in R5's MAR. In addition to those medications other medications not signed off as given on 5/12/24 include: Calcium 600 plus to be given at BED, Crestor 20 MG to be given at BED, Depakote 250 MG to be given at BED, Finasteride 5 MG to be given at BED, and Haloperidol 5 MG to be given at BED. R5's MAR shows Senna 8.6-50 MG to be given in the EVE was not signed off as given.</p> <p>R5 has been discharged from the facility and was not available to interview.</p> <p>R2, R3, and R4 active care plans were reviewed and show no refusals of medications. R5's care plan showed no refusals of medication as a problem when he was a resident at the facility.</p> <p>The facility provided Patient Centered Pass Times policy reviewed date 9/18/23 shows medications scheduled for EVE should be given between 4:00 PM and 7:59 PM, and those scheduled BED should be given between 8:00 PM and 11:59 PM.</p> <p>Staffing schedules show V5 (LPN) was scheduled to be working part of the evening and night shift on 5/12/24 on the 2nd floor.</p> <p>On 5/21/24 at 10:40 AM, V2 (Director of Nursing) verified V5 would be the nurse responsible for the 5/12/24 EVE and BED medications for the 2nd floor residents. V2 said she had received a phone call from V4 (RN) on 5/13/24 about medications still being in the cart and should have been given on 5/12/24. V2 said she contacted V5, and she told her she passed her meds but may have missed a few medications. V2 said she is aware that there is a problem at the facility with nurses not signing off medications in the MAR. V2 said that V5 is newer to the facility, and she has found issues with her knowing what med pass is considered hers and getting medications passed out. V2 said if a resident goes out to the hospital and comes back there could potentially be duplicate medications sent from pharmacy and some medications also come as duplicates in punch cards.</p> <p>On 5/21/24 at 12:32 PM, V5 said I would have passed my meds, I haven't had any issues getting them passed but I have forgotten to sign off some medications after the fact. V5 explained the 20 residents' medications still inside the medication room from 5/12/24 as maybe there were extra strips of medications in the cart that I used. V5 said there were no unusual incidents that she can recall that happened on 5/12/24.</p> <p>(continued on next page)</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On 5/21/24 at 1:40 PM, V4 (RN) said she followed V5 on 5/13/24 and when she went into the cart and started pulling the strips of resident medications there were numerous medications still in the cart from 5/12/24 that V5 had not given. V4 said she could not give those medications to the residents now it was too late, but she did give numerous residents early morning medications that were still in the cart and not given by V5. V4 said sometimes the pharmacy can send out duplicate medications if a resident is hospitalized but that was not the case for these 20 residents and their medications. V4 said she took the 5/12/24 medications and put them in the 2nd floor medication room and reported the incident to V2. V4 also said she did follow up with V5 to see the status of those medications because V5 had left. She said she believes one resident R2 may have told her he did not get his medications the night prior (5/12/24) but she did not ask residents if they got their medications or not.</p> <p>On 5/22/24 at 8:31 AM, V11 (Pharmacy- Director of Clinical Services) said she had the pharmacy pull a list of all the residents on the 2nd floors 5/12/24 medications and check if duplicate meds were sent and they were not. V11 verified that some medications come in blister packs and some in strips and V2 alerted her that sometimes medications are coming in both, so they are working on a system to see why that is happening.</p> <p>On 5/22/24 at 10:01 AM, V6 (LPN) showed the surveyor the medication cart on the 2nd floor and explained that there are times where some medications can come in both a pull strip and punch card and that typically happens with antibiotics, and sometimes psychiatric medications as well as Dilantin. V6 said the system can be very confusing and you have to pay close attention to what resident medications are in punch card and what ones are in pull strips. V6 said the expectation is to sign off the MAR as soon as the medication is given. V6 said the pharmacy has sent duplicate medications in pull strips but not 20 residents worth of medications. V6 said when a medication is not signed off and still in the cart you assume it was not given but with the duplicate medications it can be tricky to know for sure.</p> <p>On 5/22/24 at 11:15 AM, V2 said if medications are not signed off you have to assume they are not given, and with the 20 residents medications from 5/12/24 she has no way to know what was given or not. V2 said there is an issue with medications being sent in both punch cards and strips, but nurses should still be able to read the MAR and given the medication. V2 said she has had issues with V5 as well as other nurses not signing off the MAR. V2 said she has had issues with V5 in the past not giving all the scheduled medications and has given her an oral reprimand.</p> <p>The facility provided Pharmacy Policies and Procedures Manual effective 10/25/14 shows that all medications should be packaged according to facility and resident needs, and medications should be dispensed according to Prescriber orders.</p> <p>The facility provided Administering Medications policy revised 3/2024 states, The individual administering the medication shall initial the resident's Medication Administration Record (MAR) on the appropriate line and date for that specific day before administering the medication. The same policy also shows that if a MAR is not signed off the supervisor will notify the proper person to investigate if the medication. treatment was administered/performed.</p>		