

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  06/04/2024
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 - Few</p>	<p>Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.</p> <p>37232</p> <p>Based on interview and record review the facility failed to ensure a resident received their scheduled/routine pain medication and failed to document that medications were given on the Medication Administration Record (MAR) for 2 of 3 residents (R1 and R3) reviewed for pharmacy services in the sample of 3.</p> <p>The findings include:</p> <p>1. R3's face sheet showed R3 had the diagnosis of pain.</p> <p>On 6/4/24 at 10:30 AM, R3 said he missed one dose of his scheduled pain medication of hydrocodone-acetaminophen.</p> <p>R3's Medication Administration Record (MAR) showed on 5/29/24 that his scheduled bedtime pain medication was not given because it was not available.</p> <p>The facility's Patient Centered (PCC) Pass Times policy showed bedtime medications were to be given between 8:00 PM-11:59 PM.</p> <p>On 5/30/24 at 12:56 PM, V6 (Licensed Practical Nurse-LPN) said she took care of R3 on 5/29/24 from 7:00 PM to 7:00 AM on 5/30/24. V6 said she did not give R3 his scheduled bedtime pain medication on 5/29/24 because she was waiting for the pharmacy to deliver the medication. V6 said she waited for the 1:00 AM pharmacy delivery on 5/30/24 and the pain medication was not included in the delivery. V6 said after the 1:00 AM pharmacy delivery did not include R3's pain medication she contacted pharmacy. According to V6, pharmacy said the pain medication was delivered 5/29/24 at 6:28 PM. V6 said she was unable to locate R3's pain medication and called V1 (Administrator). V6 said she did not give R3 his pain medication during her shift.</p> <p>On 6/4/24 at 10:44 AM, V1 (Administrator) said R3's pain medication was delivered on 5/29/24 and placed in the narcotic overflow storage area.</p> <p>On 6/4/24 at 12:57 PM, V2 (Director of Nursing) said V6 should have contacted pharmacy when R3's pain medication was due to get authorization to remove the pain medication from the facility's medication dispensing machine.</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 - Few</p>	<p>The facility's MAC Rx Pharmacy Policies and Procedures Manual with an effective date of 10/25/14 showed regular and reliable pharmaceutical service is available to provide residents with prescription medications.</p> <p>2. R3's MAR was blank for 5/26/24 and 5/27/24 for the following medications: hydrocodone-acetaminophen, hydralazine (blood pressure) melatonin (sleeping medication), renal vitamin, and clonazepam (anxiety medication).</p> <p>R3's Controlled Drug Receipt indicated R3 received his hydrocodone-acetaminophen on 5/26/24 and 5/27/24. A count of R3's hydrocodone-acetaminophen indicated the Controlled Drug Receipt was correct.</p> <p>A facility assessment done on 5/6/24 showed R3's mental status was intact.</p> <p>On 6/4/24 at 10:30 AM, R3 said he received all of his medications on 5/26/24 and 5/27/24.</p> <p>3. R1's MAR for 5/1/24 and 5/3/24 was blank for the following medications: amlodipine (blood pressure), fluoxetine (anxiety), furosemide (water pill), roflumilast (chronic obstructive pulmonary disease), diclofenac (pain cream), and gabapentin (pain).</p> <p>A facility assessment done on 5/13/24 showed R1's mental status was intact.</p> <p>On 6/4/24 at 10:40 AM, R1 said she received all of her medications on 5/1/24 and 5/3/24.</p> <p>On 6/4/24 at 11:13 AM, V4 (Registered Nurse) said she was the nurse that was taking care of R1 on 5/1/24 and 5/3/24. V4 said she gave the medications to R1 on 5/1/24 and 5/3/24 that were blank on the MAR. V4 added that she forgot to sign off that the medications were given on the MAR.</p> <p>On 6/4/24 at 10:46 AM, V3 (LPN) said the MAR should not be blank. Medications should be checked off on the MAR as given or indicate why a medication was not given.</p> <p>The facility's Administrating Medication Policy and procedure showed the individual administering the medication shall initial the residents MAR on the appropriate line for the date for the specific day before administering the medications.</p>