STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146152	A. Building B. Wing	09/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Rochelle Gardens Care Center	1021 Caron Road Rochelle, IL 61068

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)
F 0697 Level of Harm - Actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36186 Based on interview and record review the facility failed to treat a resident's pain as ordered by the physician. This applies to one of three residents (R1) in the sample of three reviewed for pain. This failure resulted in R1 saying that being without his pain medications affects him both physically and emotionally. R1 said he was feeling shaky and nauseated. The findings include: The facility face sheet shows R1 was admitted to the facility for diagnoses to include spinal stenosis, bipolar disorder, and depression. The facility assessment dated [DATE] shows R1 to be cognitively intact. The Physician Order Sheet for September 2024 for R1 shows an order for Norco oral tablet one tablet by mouth four times a day for back pain. On 9/12/24 at 9:40 AM, V3 (Registered Nurse/RN) said when she worked on Tuesday 9/3/24, R1 was out of his prescribed pain medication Norco. V3 said a new prescription was needed from the Physician in order to get the medication from the pharmacy. V3 said she began this process right away, but the faxes were not going through to the Physician. On 9/12/24 at 10:20 AM, V1 (Administrator) said when she came to work that Tuesday 9/3/24 and heard R1 was out of his pain medications and had been for a few days, she called the Physician's office herself to try and get the situation resolved. V1 said the faxes were not going through to the Physician's office. On 9/12/24 at 10:40 AM, V2 (Director of Nursing/DON) said R1 came to her on Tuesday 9/3/24 and told her he had been without his pain medications since Sunday 9/1/24. V2 said R1 appeared anxious and tired when he came to talk to her. V2 said she could not find any documentation that shows the nurses tried to get a refill of R1's pain medication until she came in on Tuesday 9/3/24. V2 said the nurses should be requesting the prescription from the Physician and getting the new order to the pharmacy before the resident runs out of a medication. V2 said there must be very poor communication between the nurses for this to have happened. (continued on next page)

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0697 Level of Harm - Actual harm Residents Affected - Few	On 9/12/24 at 11:30 AM, R1 said on the Friday before Labor Day he asked the nurse if he had enough Norco to get through the holiday weekend and was told he did. R1 said then on Sunday the nurse told him he had run out of Norco. R1 said on Tuesday he spoke with the DON and the Administrator and told them he had not had any of pain meds since Sunday, and they told him the nurses could get the medications out of the convenience box. R1 said he heard the DON tell V3 (RN) to get him a Norco from the convenience box, but no one ever did. None of the nurses offered to. R1 said being without his pain medications affects him both physically and emotionally. R1 said he was feeling shaky and nauseated by the time he finally got the pain medication on Wednesday. On 9/12/24 at 12:25 PM, V6 (RN) said she had given the last Norco to R1 on 9/1/24 at 5:00 PM and she was not sure if a refill had been requested so she passed the information on to the next shift. The controlled substance proof of use forms for R1's Norco dated 8/16/24 shows the last Norco was given on 9/1/24 at 5:00 PM. The controlled substance proof of use form dated 9/4/24 for R1 shows a dose of Norco was given at 11:58 PM to R1. R1 missed 12 doses of his prescribed pain medication. The nursing progress notes dated from 9/1/24 to 9/4/24 shows the Norco was not given due to the medication being on order. The care plan for R1 with a revision date of 4/8/24 shows R1 is prescribed pain medications due to back pain and the interventions include administer prescribed pain medications. The facility policy with a review date of 6/24/21 for medication administration shows medications shall be administered in a safe and timely manner as prescribed. The facility said they do not have a policy for pain when one was requested.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36186 Based on interview and record review the facility failed to timely reorder a controlled substance pain medication that the pharmacy required a new prescription from the physician. This failure resulted in a delay in obtaining a prescription from the physician and the resident missing up to 12 doses of this medication. This applies to one of three residents (R1) in the sample of three reviewed for pain medications. The findings include: The facility face sheet shows R1 was admitted to the facility for diagnoses to include spinal stenosis, bipolar disorder, and depression. The facility assessment dated [DATE] shows R1 to be cognitively intact. The Physician Order Sheet for September 2024 for R1 shows an order for Norco oral tablet one tablet by mouth four times a day for back pain. On 9/12/24 at 11:30 AM, R1 said on the Friday before Labor Day he asked the nurse if he had enough Norco to get through the holiday weekend and was told he did. R1 said then on Sunday the nurse told him he had run out of Norco. R1 said on Tuesday he spoke with the DON (Director of Nursing) and the Administrator and told them he had not had any of pain meds since Sunday, and they told him the nurses could get the medications out of the convenience box. R1 said he heard the DON tell V3 (Registered Nurse/RN) to get me a Norco from the convenience box, but no one ever did. None of the nurses offered to. R1 said being without his pain medications affects him both physically and emotionally. R1 said he was feeling shaky and nauseated by the time he finally got the pain medication on Wednesday. On 9/12/24 at 9:40 AM, V3 (RN) said she was working that Tuesday 9/3/24 when R1 was out of his pain medication. V3 said she sent a fax request to the Physician for a new prescription to be sent to the pharmacy but was having trouble with the fax machine and had called the Physician office numerous times trying to get the pain medications for R1. V3 said she offered R1 a Norco from the convenience box, but he refused needing it. V3 said there are so many steps to getting a pain medication from the convenience box and they didn't have a current order anyway to get one out. V3 said a refill request should have been sent out when R1 was down to 3-4 pain pills left. On 9/12/24 at 9:50 AM, V4 (RN) said they must have an order for the Norco to get one from the convenience box. A request to the pharmacy for a refill should be started when there are 3-4 doses left of a medication. V4 said there are so many steps to getting a medication from the convenience box. On 9/12/24 at 12:00 PM, V5 (RN) said she worked 8/30/24, the Friday before Labor Day weekend. V5 said R1 had pain medication when she was working and did not have any conversations for R1 regarding his need to reorder his Norco. V5 said she did not make any attempts to get a new prescription for the Norco. On 9/12/24 at 12:25 PM, V6 (RN) said she gave R1 his last dose of Norco on 9/1/24 and said she wasn't aware if anyone had reached out to the Physician for a refill, so she passed it along in her report to the next nurse. V6 said R1 had told her V5 had requested the refill but she wasn't sure it was done. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 9/12/24 at 10:20 AM, V1 (Administrator) said when she came to work that Tuesday 9/3/24 and heard R1 was out of his pain medications and had been for a few days, she called the Physician office herself to try and get the situation resolved. V1 said the faxes were not going through to the Physician office. V1 said once the facility had a current order for the pain medication, one could be given to R1 from the convenience box. On 9/12/24 at 10:40 AM, V2 (DON) said R1 came to her on Tuesday 9/3/24 and told her he had been without his pain medications since Sunday 9/1/24. V2 said she immediately began taking steps to get the pain medication here to the facility. V2 said the pharmacy needed a new prescription for the Norco from the Physician for them to be able to dispense the Norco or to give a code to the nurses to get a Norco from the convenience box. V2 said she could not find any documentation that shows the nurses tried to get a refill of R1's pain medication until she came in on Tuesday. V2 said the nurses should be requesting the prescription from the Physician and getting the new order to the pharmacy before the resident runs out of a medication. V2 said there must be very poor communication between the nurses for this to have happened. The controlled substance proof of use forms for R1's Norco dated 8/16/24 shows the last Norco was given on 9/1/24 at 5:00 PM. The controlled substance proof of use form dated 9/4/24 for R1 shows a dose of Norco was given at 11:58 PM to R1. R1 missed 12 doses of his prescribed pain medication. The nursing progress notes dated from 9/1/24 to 9/4/24 shows the Norco was not given due to the medication being on order. A controlled medication prescription was signed by the provider on 9/3/24. The care plan for R1 with a revision date of 4/8/24 shows R1 is prescribed pain medications due to back pain and the interventions include administer prescribed pain medications. The facility policy with a review date of 6/24/21 for medication administration shows medications shall be administered in a safe and timely manner as prescribed.