

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 146152	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/26/2024
NAME OF PROVIDER OR SUPPLIER Rochelle Gardens Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0659</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide care by qualified persons according to each resident's written plan of care.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34491</p> <p>Based on observation, interview and record review, the facility failed to ensure that residents' medications were delivered by individuals who have the skills, knowledge and proper licensure for 8 of 14 residents (R1-R6, R13 and R14) reviewed for medication administration in the sample of 14.</p> <p>The findings include:</p> <p>1. R1's Admission Record, provided by the facility on 9/26/24, showed he had diagnoses including, but not limited to, chronic embolism and thrombosis of deep veins of left lower extremity (chronic blood clots), bipolar disorder, depression, hypertension, cerebral infarction (stroke), chronic pain syndrome, anxiety disorder, and suicidal ideation. R1's facility assessment dated [DATE] showed he was cognitively intact. R1's care plan initiated on 12/7/23 showed he had allergies to certain medications.</p> <p>R1's Order Summary Report, printed by the facility on 9/26/24, showed orders for pain medications, anticoagulant medications, depression medications, anxiety medications, and antipsychotic medications. R1's September 2024 MAR (Medication Administration Record) showed these medications were administered on 9/20/24.</p> <p>2. R2's Admission Record, provided by the facility on 9/26/24, showed he had diagnoses including, but not limited to, major depressive disorder, suicidal ideations, acquired absence of left and right leg below the knees, diabetes mellitus, and hypertension. R2's facility assessment dated [DATE] showed he is cognitively intact. R2's care plan initiated on 6/16/23, showed he requires the use of psychotropic medications used to manage mood and/or behavior issues. The care plan showed administer anti-depressant medication as ordered.</p> <p>R2's Order Summary Report, provided by the facility on 9/26/24, showed orders including two medications for depression, medications for pain, medications for diabetes, and medications for hypertension. R2's September 2024 MAR showed these medications were administered on 9/20/24.</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 0659</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>3. R3's Admission Record, provided by the facility on 9/26/24, showed she had diagnoses including, but not limited to, bipolar II disorder, pyoderma gangrenosum, hypertension, diabetes mellitus, anxiety disorder, major depressive disorder, epilepsy, and mild persistent asthma. R3's facility assessment dated [DATE] (provided when surveyor requested the most recent facility assessment-attached to survey) showed she was cognitively intact. R3's facility assessment dated [DATE] showed she was cognitively intact. R3's care plan initiated on 11/8/23 showed she uses psychotropic medications related to disease process of depression and bipolar II disorder. The care plan showed administer psychotropic medications as ordered by physician.</p> <p>R3's Order Summary Report, provided by the facility on 9/26/24, showed she had orders including an antipsychotic medication, an antianxiety medication, two medications for pain, and a medication for insomnia. R3's September 2024 MAR showed these medications were administered on 9/20/24.</p> <p>On 9/26/24 at 8:26 AM, R2 said the previous Friday (9/20/24) someone other than a nurse was passing medications to the residents. R2 said the person letting them do it should know better because it was V2 (Director of Nursing-DON). R2 said V2 would get the medications ready and put them in a medicine cup, then give them to V3 (Dietary Manager) to pass to the residents. R2 said V3 (Dietary Manager) was the one that gave him his medications around noon on Friday 9/20/24.</p> <p>On 9/26/24 at 8:39 AM, V4 (Certified Nursing Assistant-CNA) said she saw V3 (Dietary Manager) passing medications to the residents on 9/20/24. V4 said there was a new nurse working, she thinks it was an agency nurse. V4 said V3 was grabbing the medication cups off the medication cart and passing the medications to the residents. V4 said she heard V5 (MDS Coordinator) tell V3 that she should not be doing that. V4 said V3 also stayed overnight with a different new nurse and the residents were asking why V3 was passing medications to the residents.</p> <p>During confidential resident interviews with R5 and R6 (who were cognitively intact) on 9/26/24 at 8:49 AM, R5 said she had seen staff that were not nurses passing medications to the residents. R5 said she was not sure what their name was, but they were not one of the nurses that were working. R6 said the lady from the kitchen was passing residents their medications on Friday (9/20/24). R6 said the lady from the kitchen brought her medications into her.</p> <p>On 9/26/24 at 8:59 AM, R4 said she saw one of the kitchen staff passing medications in the last week or so. R4 identified V3 (Dietary Manager) as the kitchen staff that was passing medications to the residents. R4 said V3 gave her medications to her and to other residents.</p> <p>On 9/26/24 at 9:03 AM, R1 said V3 (Dietary Manager) gave him his medications on 9/20/24. R1 said V3 was helping V2 (DON) pass medications to the residents.</p> <p>On 9/26/24 at 9:17 AM, V5 (MDS Coordinator) said V3 was passing medications to the residents on 9/20/24. V5 said she went up to V3 (Dietary Manager) and told her that she (V3) knew better than that. V5 said she reported it to V2 (DON) when V2 came in around 9:00 AM that morning.</p> <p>On 9/26/24 at 10:25 AM, R3 said V3 (Dietary Manager) was passing medications to residents. R3 said V3 gave her (R3) her medications on Friday (9/20/24) when V2 (DON) was working as the floor nurse. R3 said V2 was preparing the medications and V3 was passing the medications to the residents. R3 said V3 also brought her medications during the night recently as well but she could not remember which day it was.</p> <p>(continued on next page)</p>		

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<p>F 0659</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On 9/26/24 at 12:41 AM, V6 (CNA) said she worked on 9/20/24 during the day shift. V6 said she saw V3 (Dietary Manager) passing medications to the residents on 9/20/24. V6 said V2 (DON) was working as the floor nurse and V3 was helping her by giving the residents their medications.</p> <p>On 9/26/24 at 2:06 PM, V1 (Administrator) said she spoke with about 10 residents. V1 said 4 of them said their medications were provided by V3 (Dietary Manager). V1 said she spoke with V3, and she said she was showing the nurse where the residents were. V1 said she spoke with V2 (DON) and she said she would never give approval to anyone that was not a nurse to pass medications. V1 said she had left several messages with V12 (Agency Nurse) and has not received a return call. V1 said V2 told her that she got in touch with V12 and V12 said she did not allow another employee to provide medications to the residents. V1 said she spoke with the facility's corporate staff, and as of right now, they cannot determine if V3 did pass medications or not.</p> <p>On 9/26/24 at 4:30 PM, V7 (CNA) said he worked the PM shift on 9/20/24. V7 said he saw V3 (Dietary Manager) passing medications to the residents during his shift on 9/20/24. V7 said there was an agency nurse (V12) working that shift. V7 said that is the first time he has ever worked with V12. V7 said V13 (CNA) was working on 9/20/24 on the same shift as him, and she saw V3 passing medications to the residents too. V12 said V13 asked him why V3 was passing medications to the residents. V7 said he saw V3 pass medications to R3, R13 and R14. This surveyor tried calling to speak with V13. V13's voicemail was full. This surveyor was not able to speak with V13.</p> <p>R1-R3's diagnoses, progress notes for the last three months, most recent facility assessments, physician's orders, and care plans were reviewed. R1-R3's facility assessments showed they were cognitively intact.</p> <p>The facility's policy and procedure, Medication Administration, with a review date of 6/24/2021, showed Medications shall be administered in a safe and timely manner, and as prescribed. The policy showed 1. Only persons licensed or permitted by this state to prepare, administer and document the administration of medications may do so.</p>		