STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146193	A. Building B. Wing	04/21/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Manor Court of Rochelle	2203 Flagg 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 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** Based on interview and record review the facility failed to ensure a physician ordered medication was administered as prescribed and failed to document medication administration for 1 of 1 resident (R1) reviewed for medication administration in the sample of 5. The findings include: 1. R1's face sheet printed on 4/21/26 showed diagnoses including but not limited to multiple sclerosis, seizures, dementia without behaviors, and generalized anxiety disorder. R1's facility assessment dated [DATE] showed moderate cognitive impairment.R1's April 2026 physician order report showed an order for alprazolam 0.25 milligrams to be given once an evening at 9:00 PM (antianxiety medication).R2's April 2026 physician order report showed an order for alprazolam 0.5 milligrams to be given once a day at bedtime 9:30 PM. On 4/21/26 at 11:15 AM, V4 (Registered Nurse) stated he accidentally gave R1 the wrong dose of alprazolam on the evening shift of 4/15/26. V4 said he gave R1 double the amount she should have received. V4 said he grabbed the wrong alprazolam medication card. V4 said he realized the error 30-40 minutes later, when he went to administer alprazolam to R2. The count was off by one tablet, and he immediately realized what had happened. V4 said R1 and R2 get similar medications around 9 PM each evening. V4 said he immediately assessed R1 and called the physician. V4 was told to continue to monitor and report back if any change in condition was noted. V4 said he continued vital signs and assessed mental status every 60-90 minutes. R1 was pleasant and at her baseline throughout the shift. V4 said he notified the on-call nurse supervisor, V3 (Assistant Director of Nurses) the same evening. V4 said he completed a medication error form and was re-educated by V2 (Director of Nurses) the next day. 2. R1's April 2026 MAR (Medication Administration Report) showed the 9:00 PM dose of alprazolam was not given on 4/14/26 (evening before the wrong dose given). The MAR was signed by V5 (Licensed Practical Nurse). The reason for not giving the medication showed other N/A. There was nothing in R1's chart explaining why the medication was not given.On 4/21/26 at 11:37 AM, V5 (LPN) stated she was sure the alprazolam was given to R1 that evening. V5 said she was not familiar with the electronic charting system yet and had only worked with it for about one week. V5 stated she should have explained why it wasn't given if that was the case. V5 said it was likely a charting error on her part, and the medication definitely was given. V5 said the MAR needs to be correct to show what is happening with the resident. Accurate charting is especially important with something like alprazolam, which is a controlled medication. V5 said she needs to refresh herself on how to use the newer electronic application before her next shift.On 4/21/26 at 11:52 AM, V2 (Director of Nurses) stated R1 did get the wrong dose of alprazolam on 4/15/26. V2 relayed the same specifics of the medication error as reported by V4. V2 said residents should always receive medications as ordered. Accurate charting is important to ensure the health and safety of the residents. The facility's Medication Administration policy dated 02/04 stated: 6. All medications must be administered to the resident in the manner and method prescribed by the physician.11. Documentation of meds given will be done in a consistent manner by the nurse placing her initials in the appropriate space on the MAR. Documentation on the MAR will be done at the time of administration of the medication.

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