STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146157	A. BUILDING _____ B. WING _____	C 05/01/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROCK FALLS REHAB & HLTH CARE C	**430 MARTIN ROAD ROCK FALLS, IL 61071**

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F 000	INITIAL COMMENTS Complaint Investigations #1512087 / IL76604 - F425 cited #1512234 / IL76790 - F309 cited	F 000		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review the facility failed to provide nursing services by not tracking or evulating resident behaviors, by not assessing the underlying cause for behaviors and by not attempting non-pharmalogical approaches to minimize behaviors for a resident with dementia. This applies to 1 of 3 residents (R1) reviewed for behaviors in the sample of 3. The findings include: On April 29, 2015 at 8:40 AM, R1 was in bed yelling while other residents were eating in the dining room. On April 29, 2015 at 12:00 PM, R1 was in dining room yelling aloud frequently and no interventions were initiated by staff. On April 29, 2015 at 12:00 PM, E4, E5 E6 and E7 (Certified Nursing Aides-CNAs) all said that they are directed by E1 (Administrator) to have R1 eat her meals either in her room or in the dining room	F 309		

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

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F 309	Continued From page 1	F 309		

when other residents are not present. The CNAs said they have voiced concerns numerous times about this intervention with E1 but are obligated to do as E1 directs. E7 stated (1:20 PM) the nurses instruct the CNAs to remove R1 from the dining room when they bring her in while other residents are eating. On 4/29/2015 at 2:00 PM, E8 CNA, said R1 is isolated even when she is not yelling or displaying a behavior.

Z1 stated she has visited the facility for sixteen months and had never seen R1 out of her room. On April 28, 2015 at 4:45 PM, Z1 stated she saw R1 dining eating alone with only staff in the dining room. Z1 stated she asked R1 if she would prefer to dine with other residents and R1 stated said yes.

On April 29, 2015 at 1:35 PM, Z3 stated facility CNAs have told Z3 the facility isolates R1 at mealtime. On April 29, 2015 at 2:30 PM, Z4 said she has been told by CNAs that the facility does not want R1 in the dining room at meal times.

On April 29, 2015 at 3:10 PM, E2 (Director of Nursing - DON) stated she expects that facility and hospice care plan should match or at least be fairly similar and that staff should follow direction of both. E2 stated that R1 sometimes yells out so she is fed right away and returned to her room because other residents complain and that any behaviors are documented in nurse's notes.

E3 (Social Services Director) and E1 state R1's yelling is not a behavior but rather a symptom of her dementia. E3 stated that R1 received medication to decrease the yelling as an intervention but the medication is no longer available. E1 was unable to state what interventions were used to reduce R1's yelling.

R1's facility care plan started on August 16, 2012 and updated on April 1, 2015 addresses behavior as a problem. On April 29, 2015 at 4:15 PM, E3

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F 309	Continued From page 2 said they give R1 wash cloths to hold during care to keep hands busy. The care plan does not show any review or revision of nterventions. R1's February 17, 2015 psychosocial care plan documents behavior exhibited- yelling. R1's hospice care plan (dated August 21, 2014) identified social isolation as a problem and R1 is isolated related to constantly yelling out. R1's hospice care plan (dated December 22, 2014) shows R1 yells out. R1's March and April 2015 Medication Administration Record documents Morphine and Ativan were given for yelling on March 18,19,28 & 29th and April 16,18 (twice), 22 and 29th (twice). The care plan dated February 19, 2015 documents R1's history of Alzheimer's dementia. Behaviors are documented once in the nurses notes March 2015 and none in April 2015. .	F 309		
F 425 SS=D	483.60(a),(b) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. The facility must employ or obtain the services of a licensed pharmacist who provides consultation	F 425		

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F 425	Continued From page 3 on all aspects of the provision of pharmacy services in the facility. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review the facility failed to ensure physician prescribed pain medications were available to a resident. This applies to 1 of 3 residents (R3) reviewed for medications in the sample of 3. The findings include: R3's Physician Order Sheet dated 4/1/15 shows diagnoses to include Drug Abuse, Alcohol Abuse, Chronic Back Pain, Peptic Ulcer Disease, and Colitis. R3's Minimum Data Set (MDS) of 11/24/14 shows R3 requires minimal assistance with transfers, ambulation, dressing, hygiene, and bathing. On 4/29/15 at 9:30 AM, R3 finished his breakfast and used a walker to ambulate to his room. R3 changed positions several times and placed pillows behind his back. R3 said it was difficult to get comfortable because he had three back surgeries and has a plate in his neck. R3 said the doctor has ordered the medication, but he had to wait 6 days for the Norco to be available at the facility once, and waited 5 days for the Norco to be available the second time. R3 said "I was having pain while I waited for the new meds to come ...I had pain in my lower back, upper back, and down my right arm". E3 said he asked everyday for his Norco and wanted to know why it was not at the facility yet. R3's January 2015 Physician Order Sheet (POS) shows the Norco was order on 1/22/15, and the	F 425		

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F 425	Continued From page 4	F 425		

pharmacy delivery date was 1/28/15 -- 6 days after the order. R3's Facility January 2015 Medication Administrator Record (MAR) shows R3 did not receive a dose of Norco until 1/29/15. R3's March 2015 POS shows Norco was re-ordered on 3/3/15, and the pharmacy delivery date was 3/10/15 -- 7 days after the order. The March 2015 MAR shows R3 did not receive a dose of Norco until 3/11/15.

On 4/29/15 at 1:30 PM, E9 (LPN - Licensed Practical Nurse) said the pharmacy will not fill a prescription for narcotics without the physicians DEA (Drug Enforcement Agency) number. E9 said the facility will fax the order to the pharmacy but if it is not signed with the DEA number, the pharmacy will either notify the facility or attempt to call the doctor. E9 said the facility nurse should contact the doctor and get his number so the order can be processed but if it's a weekend it can take over three days to get his number because he may not be available.

On 4/29/15 at 1:45 PM, E10 (LPN - MDS Coordinator) said the order written on 1/24 for the Norco was not signed by R3's medical physician. E10 said the order was written on Thursday and Z1 (Physician) is not in the office on Friday, and it would automatically be 3 days before the Norco was filled. E10 said the same thing happened with the Norco that was ordered on 3/5/15; it was ordered on Thursday but not signed with Z1's DEA number. E10 said the pharmacy would not fill the order until they had the physician's signature and DEA number. E10 said R3 was asking for his Norco on both occasions and would sit at the front of the facility waiting for his pain medication to arrive at the facility.

On 4/29/15 at 3:30 PM, E11 (LPN) said the pharmacy will not fill an order for the Norco until the physician signs the order with the DEA

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F 425	Continued From page 5 number. E11 said R3 has complained about his Norco not being available and has had to wait for his meds to be delivered. E11 said she writes a fax for the physician to obtain their signature and DEA number and the day nurse faxes it to him. E11 said this is done so the order can be processed by pharmacy. On 4/29/15 at 2:10 PM, E2 (DON-Director of Nursing) said if an order is written before 3:00 PM it should be delivered by the pharmacy that evening. E2 said the nurses cannot take the Norco from the facility supply because there is a code on the supply that has to be entered before it can be opened. E2 said the code comes from the pharmacy and they will not release it if they do not have the physician's DEA number. E2 said R3's doctor did not sign the order with his DEA number and the nurse should have called him or called the on call doctor to get the order processed. E2 said the nurses should not have waited days for the physician to correctly sign the order without calling the physician. On 4/29/15 at 1:45 Pm, E1 (Administrator) and E3 (Social Service Director) said they knew that R3 was waiting on both occasions for his pain med. E1 and E3 said R3 would ask for his pain medication and would sit by the front door each day and wait for the pharmacy to deliver it. The 7/3/13 facility Medication Administration policy states "Medications must be prepared and administered within one hour of the designated time or as ordered".	F 425		