Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6008098	A. BUILDING: ______ B. WING ______	R-C 12/20/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROCHELLE GARDENS CARE CENTER	1021 CARON ROAD ROCHELLE, IL 61068

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{S 000}	Initial Comments First Complaint Certification Revisit to Survey date September 7, 2023. Complaint Investigation: 2317217/IL163808 2317235/IL163837	{S 000}		
{S9999}	Final Observations Statement of Licensure Violations I of II: 300.610a) 300.1210b) 300.1210c) 300.1210d)2)3) 300.3240a) Section 300.610 Resident Care Policies a) The facility shall have written policies and procedures governing all services provided by the facility. The written policies and procedures shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee, and representatives of nursing and other services in the facility. The policies shall comply with the Act and this Part. The written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, documented by written, signed and dated minutes of the meeting. Section 300.1210 General Requirements for Nursing and Personal Care b) The facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive resident care plan. Adequate and properly supervised nursing	{S9999}	Attachment A Statement of Licensure Violations	

Illinois Department of Public Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE　　TITLE　　(X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6008098	A. BUILDING: ____ B. WING ____	R-C 12/20/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROCHELLE GARDENS CARE CENTER	1021 CARON ROAD ROCHELLE, IL 61068

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{S9999}	Continued From page 1	{S9999}		

care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident.
c) Each direct care-giving staff shall review and be knowledgeable about his or her residents' respective resident care plan.

d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour, seven-day-a-week basis:
2) All treatments and procedures shall be administered as ordered by the physician.
3) Objective observations of changes in a resident's condition, including mental and emotional changes, as a means for analyzing and determining care required and the need for further medical evaluation and treatment shall be made by nursing staff and recorded in the resident's medical record.

Section 300.3240 Abuse and Neglect
a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. (Section 2-107 of the Act)

This REQUIREMENT is not met as evidenced by:

Based on interview and record review, the facility failed to monitor a resident's respiratory status as ordered for a resident with a history of respiratory failure and mechanical ventilation resulting in death for 1 out of 3 residents (R512) reviewed for respiratory care in the sample of 17.

The findings include:

R512's face sheet showed a 59-year-old female

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6008098	A. BUILDING: ______ B. WING ______	R-C 12/20/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROCHELLE GARDENS CARE CENTER	1021 CARON ROAD ROCHELLE, IL 61068

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{S9999}	Continued From page 2	{S9999}		

with diagnosis of acute and chronic respiratory failure with hypoxia (low oxygen) and hypercapnia (high carbon dioxide), obstructive sleep apnea, pneumonia, schizophrenia, bipolar disorder, asthma, hypertension, and morbid obesity.

On 12/13/23 at 12:00 PM, V6 (Registered Nurse/RN) said R512's condition was "very fragile", her oxygen saturations dropped easily. V6 said R512's oxygen nasal cannula fell out of her nose frequently and was noncompliant with it at times.

On 12/13/23 at 1:15 PM, V10 (Certified Nursing Assistant/CNA) said on 9/28/23 around 8:30 PM, she was passing snacks and found R512 cold and unresponsive to verbalization and touch. V10 said R512's mouth was "bluish". R512 was on laying on her stomach with her arms outstretched over her head face down. V10 said she ran to get help. V10 said it took about 5-6 minutes for her, V7 (Licensed Practical Nurse/LPN) and V9 (CNA) to turn R512 onto her back to start CPR. V10 said V9 started chest compressions. V9 and V10 (CNA) said after they started CPR, V7 told them to call 911. V9 said (and V10 confirmed), V9 tossed her personal cell phone to V7 to call 911.

On 12/13/23 at 2:12 PM, V9 (CNA) said on 9/28/23 she was coming down the hall and V10 yelled at her to hurry up, she needed help, and "she" (R512) was not breathing. V9 said she entered R512's room and she tapped on R512's shoulder and did not get a response. V9 said she and V10 ran down the hall to get V7. V9 said it took about five to six minutes to turn R512 onto her back to start CPR (cardiopulmonary resuscitation). V9 said "I know they were not checking on her like they were supposed to. What p****d me off was as soon as everyone

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6008098	A. BUILDING: ______ B. WING ______	R-C 12/20/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROCHELLE GARDENS CARE CENTER	1021 CARON ROAD ROCHELLE, IL 61068

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{S9999}	Continued From page 3	{S9999}		

showed up (police paramedics), V7 told V8 (CNA) to say she checked on R512 and instructed all of us not to say anything else. "The cops heard me, V8 and V10 arguing". R512's dinner tray was still there, and she would normally eat as soon as it was placed down. R512's dinner tray had not been touched. We were arguing about her tray not being picked up and R512 not being checked. V8 sat at the nurses' desk most of the shift up to that point. R512 was V8's responsibility that shift and she does not allow me or V10 to touch or check on her residents. V9 said she and V10 told the police V8 had not checked on R512 and showed the officer the absence of documentation in the medical record. V9 said "I was praying someone would look at this injustice". V9 said snacks are passed around 8:30 PM so this all happened around 9:00 PM. V9 said V1 (Administrator) texted her to let her know IDPH would be calling her and instructed her to be vague and not tell them everything. V9 sent this surveyor a screenshot of V1's text message sent on 12/13/23 at 2:07 PM which said- IDPH is going to call you about R512's death. Leave it vague, you started compressions, you weren't sure what the time frame was.

On 12/13/23 at 2:46 PM, V1 (Administrator) reviewed R512's monitoring documentation and confirmed there was no evidence to show R512 was checked after 5:45 PM on 9/28/23. Additional evidence of every 15-minute monitoring was requested and not received.

On 12/14/23 at 8:15 AM, V12 (Local Fire Department Lieutenant Paramedic) said he was on the scene at the facility 9/28/23 regarding R512 and "their timeline didn't add up".

On 12/14/23 at 9:40 AM, V11 (RN) said R512's

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{S9999}	Continued From page 4	{S9999}		

oxygen saturations would drop quickly. V11 said R512 could be fine one second and her oxygen could drop the next. That's why she was on 15-minute checks, to make sure her oxygen was kept on. R512 had a lot of hospitalizations related to respiratory failure and had been intubated (placed on mechanical ventilation). She was intubated almost any time we sent her out. The CNAs do the 15-minute checks, and we did hers to prevent her death. "I'm sure she could die if they weren't done". The checks are documented for accountability. The CNAs on night shift prefer to do their own assignments and no one else. It was difficult to work with. That's why I left that shift.

On 12/14/23 at 10:11 AM, V7 (LPN) said R512 took her oxygen off "a lot" and was chronically in and out of the hospital for breathing issues. V7 said R512 had been on a "ventilator numerous times". V7 said R512 was on 15-minute checks because of her breathing, oxygen saturations dropping, to make sure she was compliant with the oxygen, and to check on her respiratory status. V7 said if 15-minute checks were not done a resident could "code and die. Anybody can". V7 said the CNAs do the 15-minute checks for R512. V7 was asked how she ensured R512's 15-minute checks were done she said, "I rely on the CNAs to let me know if there are any issues and trust them to do their jobs". V7 said if checks aren't documented they weren't done. V7 said on 9/28/23 at 8:50 PM (when R512 was found unresponsive) was the first time on her shift that she had set eyes on R512 (shift started at 6 PM). V7 said it took about two to three minutes to position R512 on her back to start Cardiopulmonary Resuscitation (CPR) and that was "way too long". "It was frightening and impaired our resuscitation efforts". V7 said

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6008098	A. BUILDING: ______ B. WING ______	R-C 12/20/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROCHELLE GARDENS CARE CENTER	1021 CARON ROAD ROCHELLE, IL 61068

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{S9999}	Continued From page 5	{S9999}		

R512's dinner tray was still at the bedside.

On 12/14/23 at 12:33 PM, V3 (Medical Director) said he ordered 15-minute checks for R512 to make sure she was stable and had her oxygen on. V3 said due to R512's body habitus, chronic respiratory issues, and diagnosis of obesity hypoventilation syndrome, she was "100% at great risk for respiratory failure". V3 said if R512 was not checked as ordered respiratory and cardiac compromise, hypoxia, and death would be possible. V3 said R512 was not always compliant with her oxygen so it was important to check her frequently.

On 12/18/23 at 3:16 PM, V19 (Paramedic) said when he arrived at the facility on 9/28/23 the nurse was at the desk and two CNAs were in the room doing CPR on R512. R512 was "definitely" cyanotic (blue color), and the timeline didn't make sense. We got the call about 9:10 PM and we were told it took a while to get her on her back and they said they did CPR for 10 minutes before calling us. V19 said they had picked R512 up at the facility numerous times for respiratory issues and R512 had been intubated in the past.

R512's census report showed hospital leaves 8/18/23-8/22/23 and 9/8/23-9/13/23.

R512's discharge summary and orders from her last hospitalization was requested and not received. V2 and V23 (Regional Clinical Director) were unable to find them onsite.

R512's physician order sheet showed a 9/15/23 order to titrate oxygen to keep saturations at 88% per nasal cannula every shift related to acute and chronic respiratory failure. Another 9/15/23 order showed to obtain a SPO2 (oxygen saturation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6008098	A. BUILDING: ______ B. WING ______	R-C 12/20/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROCHELLE GARDENS CARE CENTER	1021 CARON ROAD ROCHELLE, IL 61068

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{S9999}	Continued From page 6	{S9999}		

level) every shift.

A facility policy for titrating oxygen was requested and none was received.

R512's oxygen saturation checks showed no checks done on 9/25/23 and one check was done on 9/26/23.

R512's physician order sheet showed a 9/13/23 order for resident to be checked every 15 minutes and an order for a full code.

R512's monitoring document showed R512 was last checked on 9/28/23 at 5:45 PM. Additional resident monitoring documentation was requested and not received.

R512's 9/25/23 progress note showed V17 (R512's Son/Power of Attorney) called 911 as he wanted her transferred to a different facility because her oxygen was off, and staff were not doing 15-minute checks. V17 said he was in R512's room for 30 minutes and staff did not check on her. On 12/14/23 at 3:17 PM, V17 confirmed he wanted his mother moved because the staff were not checking on her.

R512's 9/28/23 10:52 PM progress note showed at approximately 8:50 PM, staff CNA called for the nurse to examine resident as it looked like she was not breathing. R512 was laying on her belly face down into her breasts. There was no pulse and no oxygen saturation reading.

R512's 9/28/23 progress note showed R512's time of death was 9:37 PM.

R512's 11/7/23 death certificate showed the cause of death was acute and chronic respiratory

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6008098	A. BUILDING: ______ B. WING ______	R-C 12/20/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROCHELLE GARDENS CARE CENTER	1021 CARON ROAD ROCHELLE, IL 61068

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{S9999}	Continued From page 7 failure. The 9/29/23 local fire department report showed staff said they contacted 911 at 9:10 PM after approximately 10 minutes of repositioning the resident and starting CPR. The report showed the crew arrived at the facility on 9/28/23 at 9:15 PM and R512 was cyanotic and without respirations or heartbeat. The 9/29/23 local police department report showed V17 told police he believed R512 was neglected and not getting the proper treatment at the facility. R512's care plan showed she was on oxygen and required supplemental oxygenation when sleeping and throughout the day; to monitor for changes in respiratory rate or depth. Observe/document for use of accessory muscles. Notify MD of significant changes. R512's reactive airway/asthma care plan showed to monitor vital signs every shift and as needed, skin color, pulse oximetry, airway functioning, and degree of restlessness which may indicate hypoxia. R512"s shortness of breath care plan showed to monitor/document changes in orientation, increased restlessness, anxiety, and air hunger. Monitor/document breathing patterns. R512's 9/20/23 provider note showed she had been in and out of the hospital recently for respiratory distress and was intubated. This note showed the need to monitor R512 very closely and they will keep a close eye on her. The facility's 10/06 Resident Monitoring Policy	{S9999}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6008098	A. BUILDING: ____ B. WING ____	R-C 12/20/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROCHELLE GARDENS CARE CENTER	1021 CARON ROAD ROCHELLE, IL 61068

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{S9999}	Continued From page 8	{S9999}		

showed resident monitoring is done to assist in providing safety to residents that are a potential threat to self. Document all assessments in the resident medical record.

The facility's 3/19 Oxygen Policy showed oxygen is administered to promote adequate oxygenation and provide relief of symptoms of respiratory distress.

R512's 9/27/23 nutrition note showed she was 66 inches tall and weighed 512 pounds.

"AA"

Statement of Licensure Violations II of II:
300.610a)
300.620a)

Section 300.610 Resident Care Policies
a) The facility shall have written policies and procedures governing all services provided by the facility. The written policies and procedures shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee, and representatives of nursing and other services in the facility. The policies shall comply with the Act and this Part. The written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, documented by written, signed and dated minutes of the meeting.

Section 300.620 Admission, Retention and Discharge Policies
a) All involuntary discharges and transfers shall be in accordance with Sections 3-401 through 3-423 of the Act.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6008098	A. BUILDING: ______ B. WING ______	R-C 12/20/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROCHELLE GARDENS CARE CENTER	1021 CARON ROAD ROCHELLE, IL 61068

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{S9999}	Continued From page 9	{S9999}		

This REQUIREMENT is not met as evidenced by:

Based on interview and record review the facility failed to ensure a resident with a history of mental illness and known substance abuse was permitted back to the facility after an emergency room visit resulting in R511 staying at a homeless shelter and nowhere to go. This applies to 1 of 4 (R511) residents reviewed for discharge in the sample of 17.

The findings include:

R511's electronic medical records (EMR) show he is a 55-year-old male admitted to the facility on July 21, 2023. His diagnoses to be included: anxiety disorder, alcohol dependence, suicide attempt, suicidal ideations, and major depressive disorder.

R511's progress notes dated October 23, 2023 at 9:53 AM shows, "At approx. (approximately) 0935 (9:35 AM) resident (R511) approached V11 (Registered Nurse/RN) et (and) stated, "I need to go to the hospital, my leg hurts." Resident does have positive doppler for DVT (deep vein thrombosis) in L (left) leg. MD (medical doctor) aware et gave referral to hematology et appt (appointment) is to be set up by transportation dept (department). RN told resident that orders need to be obtained prior to being transferred out to the ED (emergency department). Resident stated, "What doctor? V3 (Medical Doctor)? I fired him." Resident then stated, "I want to go to local hospital in another town." RN made

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{S9999}	Continued From page 10 resident aware that if he wanted to be taken to the ED, that he would have to go to the local hospital in town. Resident stated, "I'd rather die than go there" et walked away..." The same progress notes show at 10:18 AM, "At approx. 1010 (10:10 AM) EMS (emergency medical services) arrived to facility. Staff did not call emergency services, EMS stated that R511 called for himself. V11 (RN) relayed the conversation between RN et R511 at approx. 0930 (9:30 AM). R511 was taken to local ED via EMS services..." Another progress note at 2:21 PM shows, "This RN called local hospital at approx. 2:05 PM for an update on resident. Local ED RN stated that resident R511 left AMA (against medical advice) from the ED at approx. 1355 (1:55 PM) ..." R511's ED MD progress notes dated October 23, 2023 shows, "HPI (history of presenting illness) patient is a 55-year-old male who presents to the emergency department with complaints of left leg pain. Patient presents brought by EMS from nursing home facility and recently has been diagnosed with a DVT in his left leg. Patient is already on anticoagulation. Patient per nursing home report had left for weekend on leave from nursing home and reportedly took all his Norco (pain medication) medication leaving him with no pain medication left to take. His nursing home physician had decided that he was not going to refill the patient's pain medication, reportedly because of the patient taking all his medications over the weekend..." The same report continues to show, "Disposition: AMA (against medical advice); differential diagnosis: acute on chronic DVT, arterial insufficiency, arterial occlusion left leg, chronic pain, PAIN MEDICATION SEEKING BEHAVIOR, tension headache, migraine headache, intracranial bleed less likely; Medical decision making: I reviewed the patient's past	{S9999}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6008098	A. BUILDING: ______ B. WING ______	R-C 12/20/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROCHELLE GARDENS CARE CENTER	1021 CARON ROAD ROCHELLE, IL 61068

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{S9999}	Continued From page 11	{S9999}		

medical history, any pertinent or available previous medical visits, pertinent previous test results, imaging, laboratory tests, etc., and reviewed current nursing notes and vital signs. Patient presents with above history and exam. History exam are consistent with patient having a nonspecific headache and a complaint of a persistent left lower leg pain. Patient is repeatedly complaining of pain and the patient recently ran out of his Norco medication and was repeatedly asking the ambulance crew for pain medication and repeatedly asking the emergency department staff and myself for pain medication. Patient presentation is concerning for pain medication seeking behavior... The patient at this time eloped from the emergency department as the patient was repeatedly asking for pain medication. He was given Decadron intramuscularly. Opioid pain medication was avoided as the patient was undergoing workup because the patient has recently overused his Opioid pain medication in the outpatient setting and has been exhibiting pain medication seeking behavior. The patient eloped from the emergency department..."

R511's progress notes dated October 23, 2023 at 6:01 PM shows, "At approx. 1615 (4:15 PM), this V6 RN was informed by R515 that he had spoken to R511 on the phone around 1400 (2:00PM). R511 told R515 that he was at a local store buying soda et informed R515 that he would not be returning to facility. R515 then informed this nurse at approx. 1650 (4:50 PM) that he had received a phone call from his local group counselor stating he saw R511 walking near a local mart intoxicated. Counselor stated R511 was stumbling, speaking incoherently, et missing a shoe et proceeded to walk R511 back to the facility. At approx. 1712 (5:12 PM), local police

{S9999} Continued From page 12 {S9999}

department were called by staff to report R511, dispatch stated police were already on scene. A local resident called 911 suspecting suspicious behavior. Counselor called this RN via resident's R515 phone stating pt (patient) R511 was transported to local hospital. Pt hurt his back d/t (due to) fall he endured during police encounter. D/t refusal of treatments, reoccurring inebriated episodes, drug seeking behaviors et for safety of the residents et staff, Administration et corporate WILL NOT be accepting R511 back into facility. Facility is unable to provide appropriate care et meet his needs at this time. Pt requires rehab for substance abuse..."

R511's progress notes show no other progress notes written after October 23, 2023 at 6:01 PM.

On December 14, 2023 at 10:05 AM, V5 (RN) stated, V1 (Administrator) told her R511 was not allowed back to the facility on October 23, 2023 because he left the hospital AMA and was intoxicated. She stated, she called the police to let them know R511 was on his way back to the facility and was not allowed at the facility per V1 (Administrator).

Upon listening to police audio on October 23, 2023 at 5:16 PM V5 (RN) is heard calling the police department saying resident called 911 earlier and went to the hospital. He left the hospital AMA. He went to a local bar got "belligerent, drunk" and they needed a police escort. He was no longer allowed on the property according to corporate because they were not a "rehab facility." The police dispatch asks V5 (RN), "You want him removed from the property?" V5 states, he is not actually at the facility but was walking there now. He called another resident and was walking to the facility at the time of the

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{S9999}	Continued From page 13	{S9999}		

call. She stated, "They don't want him to come to the facility." The police dispatch asks the name of the resident. V5 states, it is R511. The police dispatch goes on to state, there was already an officer with him at the time of the call. The call ends.

R511's local ED MD progress notes dated October 23, 2023 (2nd time going to the ED) shows, "Chief Compliant: Patient presents with Alcohol Intoxication, pt found in front of school intoxicated. HPI patient is a 55-year-old male who presents to the emergency department brought by EMS and police after the police was found outside exhibiting public intoxication. The patient was found walking around and sitting in front of a school. The patient was noted to be intoxicated. Patient has recently left AMA/eloped from the emergency department before his results were obtained. Patient was becoming belligerent and disgruntled because he was not receiving Opioid pain medication after recently taking too much of his medication too quickly and running out of his medication. The patient now is brought to the emergency department with no specific complaint other than being found in public with public intoxication... Medical decision making: ...History exam is consistent with patient being brought to the emergency department for alcohol intoxication. The patient does not exhibit any signs of any injury at this time. The patient is ambulatory upon arrival in the emergency department and the patient is verbally abusive and belligerent and verbally aggressive towards myself and the medical staff. The patient is ambulating in the emergency department getting close to the staff and myself and exhibiting signs of intimidation and threatening type behaviors. Therefore, the patient was given intramuscularly Haldol (anti-psychotic) and intramuscularly Ativan

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6008098	A. BUILDING: ______ B. WING ______	R-C 12/20/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROCHELLE GARDENS CARE CENTER	1021 CARON ROAD ROCHELLE, IL 61068

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{S9999}	Continued From page 14	{S9999}		

(anti-anxiety). Police remained in the emergency department to observe the patient until patient became calm and cooperative. Patient then rested and was sleeping on the emergency department cot. Patient was allowed to sober up and eventually was given a meal.... After period of observation in the emergency department until the patient was calm, cooperative, oriented, and ambulatory without difficulty and stable for discharge patient was then discharged with his belongings. Patient is not allowed back to the nursing home where he resides because he had showed up at the nursing home intoxicated and belligerent prior to coming to the emergency department and then being found out in public intoxicated, therefore patient is being discharged in the care of the local police who will further ensure the patients safety upon discharge..."

On December 14, 2023 at 10:05 AM, V5 (RN) stated R511 never came to the facility on October 23, 2023. He was walking to the facility when the police were called by a local resident. The police found R511 by the school. R511 was being aggressive with police and EMS so they took him to the local emergency department. V5 did tell the police that R511 was not allowed at the facility per V1 (Administrator).

On December 18, 2023 at 10:05 AM, V20 (ED RN) stated, she couldn't remember who she spoke with at the facility but she spoke to someone at the facility that stated, R511 was not allowed back to the facility because he had showed up intoxicated being aggressive (V5 RN confirmed that R511 never actually made it back to the facility but was walking back and police found him first). The only way he could come back was with a police escort to pick up his belongings, but he was not able to stay at the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6008098	(X2) MULTIPLE CONSTRUCTION A. BUILDING: ______ B. WING ______	(X3) DATE SURVEY COMPLETED R-C 12/20/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROCHELLE GARDENS CARE CENTER	1021 CARON ROAD ROCHELLE, IL 61068

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{S9999}	Continued From page 15	{S9999}		

facility. She stated, at the time of that phone call it was R511's second time in the ED that day. He had come originally because the facility wouldn't give him any pain medication due to him going out on pass over the weekend with all his pain medication. He came back to the facility with no pain medication, so the Doctor refused to give him anymore pain medication. The second time he came back he was intoxicated.

The ED nursing notes for R511 dated October 23, 2023 at 5:11 PM shows, "Spoke with V5 RN at facility. V5 RN states her administrator spoke with corporate and due to pt returning to facility intoxicated and aggressive, he is not allowed to return there. He may only return with police escort to get his belongings." (V5 RN confirmed that R511 never actually made it back to the facility but was walking back and police found him first). The same nursing notes at 12:18 PM shows, R511 was discharged from the ED with the local police department.

On December 13, 2023 at 12:43 PM, V1 (Administrator) stated, R511 went to one of the homeless shelters. She stated, he showed back up to the facility "2-3 days later" with his counselor to pick up his belongings.

R511's progress notes do not show any other progress notes besides the last progress note dated October 23, 2023.

Upon listening to police audio on October 24, 2023 (the next day) at 1:44 PM V1 (Administrator) is heard calling the police department saying she was the administrator at the facility, and they had a resident leave AMA. He was no longer a resident because he was gone for more than 24 hours (failed to mention they refused to take him

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{S9999}	Continued From page 16 back the day before). He was refusing to leave and "she can't have him in the building." She told him he could take his belongings, or they could hold on to them for 30 days. He was refusing to leave. He became violent at the hospital and left AMA. The police dispatch asks how long he has been out of the facility, V1 (Administrator) states, just a day. The police dispatch asks what the residents name is. V1 states, it is R511. The police dispatch then asks where he was. V1 states, he is refusing to get up and pretending to sleep. He was lying in room 26 (his room when he was there with all his belongings still there). The police dispatch puts V1 on hold until she comes back and asks if an officer was there. V1 confirms there was an officer there and the call ends. On December 14, 2023 at 11:13 PM, V1 states, she never called the police and R511 never came the next day. It was "2-3 days later with his counselor" to get his belongings. He never went any further than the front desk/door. She confirmed that he left the hospital AMA but never the left the facility AMA. The local ED MD progress notes on October 24, 2023 at 6:57 PM shows, "Patient presents with c/o (complained of) left leg pain which he has had due to a chronic DVT in the leg. He was seen here yesterday and had imaging with ultrasound both venous and arterial which was consistent with prior scan. He was residing at a local NH (nursing home), apparently left the ED last evening/eloped without being transferred back to the NH, and was upset as his NH doctor took him off of Norco and the ED refused to give RX (prescription); he then had some alcohol and then returned to NH where they refused to re-admit the patient; He has since been out walking around	{S9999}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6008098	A. BUILDING: ______ B. WING ______	R-C 12/20/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROCHELLE GARDENS CARE CENTER	1021 CARON ROAD ROCHELLE, IL 61068

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{S9999}	Continued From page 17	{S9999}		

town today, per EMS had an interaction with police earlier, and admitted to drinking more alcohol tonight... Medical Decision Making: Patient with alcohol intoxication, recently absconded from local NH, he states he was homeless prior; DVT appears chronic; same location as prior U/S (ultrasound), and he is on Xarelto (blood thinner), medications were given to patient at NH when he returned and was refused admission; this seems to be a social visit, and pain medication seeking behavior, will observe and discuss with discharge planning in the am for nursing home placement."

The ED nursing notes for R511 on October 24, 2023 shows, local police department were called to assist with placement at local shelter. The police department called back stating, the local shelter is "unable to offer pt a room due to it being a one-time thing (On October 23, 2023). Pt was supposed to follow up with local shelter for placement but did not." "Agreeable to looking for nursing facility placement in AM..."

The ED nursing notes for R511 on October 25, 2023 shows, the facility was called and waiting a call back. The facility was called again and waiting for call back from V14 (Social Service Director). "Pt notified we called facility and are waiting for a call back. They will call us sometime after 2 PM and we will call him to let him know if there is anything they can suggest for housing. Pt notified in the meantime he should go to local shelter if he needs shelter/housing. Address and phone number provided. Pt voiced understanding. Pt dcd (discharged) amb (ambulatory) with all belongings with steady gait."

On December 13, 2023 at 2:21 PM, V16 (R511's sister) stated, she didn't know much about what

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6008098	A. BUILDING: ______ B. WING ______	R-C 12/20/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROCHELLE GARDENS CARE CENTER	1021 CARON ROAD ROCHELLE, IL 61068

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{S9999}	Continued From page 18	{S9999}		

happened. The only thing she knew was "the facility gave him a bag of meds and put him on the street."

On December 19, 2023 at 11:03 AM, R511 stated, V1 (Administrator) told him he couldn't stay at the facility anymore. He told her he didn't have anywhere to go. She called the police. I told them I didn't have anywhere to go but they said he had to leave the property. He stated, he didn't know what he was going to do. "It was cold that day, freezing. I only had a little coat. I didn't know what to do. I was kind of stuck."

R511's progress notes from various dates at the facility show:

On September 10, 2023, "This V5 (RN) walked into pt room at approx. 7:20 PM to give HS (hour of sleep) medication. Pt medication complaint. S/Sx (signs and symptoms) of slurred, loud, incoherent speech, et incoordination present at this time. PT stated he went on a walk around 11am and drank liquor at a bar. Pt unable to state amount ingested..."

On September 13, 2023 at 3:56 PM, "Resident came up to the nurses' station stating he was going to leave and come back. Resident is slurring his words and yelling at staff. This V15 (RN) reported that he was unable to go out without someone signing him out. Resident got very belligerent and started screaming at staff. Resident got increasingly aggressive. Police were called and tried to calm the resident down. After police left resident came back up to the nurses' station and started yelling at staff, and then demanded his Norco. This nurse was uncomfortable giving resident a Norco not knowing if resident was on another type of

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6008098	A. BUILDING: ______ B. WING ______	R-C 12/20/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROCHELLE GARDENS CARE CENTER	1021 CARON ROAD ROCHELLE, IL 61068

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{S9999}	Continued From page 19	{S9999}		

substance. MD notified and stated that is was ok to send resident to the ER (emergency room) for a drug and alcohol screen." At 4:44 PM, "Resident refused to have a drug and alcohol screen at ER. Resident has remained in his room, not yelling or aggressive with staff at this time." At 6:12 PM, "Resident has not continued yelling since previous incident earlier this shift or displayed further aggressive behavior, however, resident is walking around the facility and slurring words while talking to other residents. When resident is walking, he is not able to walk in a straight line. Resident still appears to be possible intoxicated."

On September 23, 2023 at 9:17 AM, "While nurse was helping another resident and on the phone with a pharmacist, this resident came up close to the care and asking for his pain medication while this nurse was still on the phone with the pharmacy. This nurse told this resident that he would have to wait until this nurse was done helping someone else. Resident then started yelling and cussing out this nurse and stated that this nurse was denying him. This nurse never stated resident could not receive the pain medication, only that resident would have to wait until this nurse was off the phone and finished helping the other resident. This resident then started yelling and getting more aggressive and eventually went back into his room."

On September 24, 2023 at 4:00 PM, "At approx. 1550 (3:50 PM) fire alarm system was triggered, south B hall zone was searched. Resident found in room XX with 2 other residents. Air in room XX had a dense, thick smoke like appearance resembling smoke emitted from e-cigarettes. Pt et roommates denies smoking e-cigarette et source of smoke with questioned. When

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6008098	A. BUILDING: ______ B. WING ______	R-C 12/20/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROCHELLE GARDENS CARE CENTER	1021 CARON ROAD ROCHELLE, IL 61068

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{S9999}	Continued From page 20 questioned again, pt stated he didn't have a vape then stated later that he could go for a walk and smoke his vape if he wanted to... Pt told this nurse to "f**k off" et returned to room..." On October 12, 2023, "Res (resident) left for HV (home visit) with brother. 33 tabs of Norco went with him, and the rest of meds explained and marked for when to take them. States will return on Sunday afternoon sometime. Clarification on his Norco. It is to be given every 8 hours PRN. Norco cards fixed to say every 8 hours not 6 hours." On October 15, 2023, "Pt arrived back to facility around approx. 3pm. Upon assessment of pt medications RN noted that pt left with 33 pills of hydrocodone on 10/12 at 1900 (7:00 PM) with last pill taken at 1830 (6:30 PM). Pt returned to facility with 16 remaining narcotics. Per V3 Medical Doctor pt will no longer be receiving narcotics and will need to see a pain specialist..." R511's MD progress notes dated July 24, 2023 shows, "Chief Complaint: Admission to facility. History of Presenting Illness: This is a 55-year-old gentleman not previously known to me. Patient has had a very significant past medical history with regard to vascular complications. Most recently he was hospitalized with complications from his chronic alcohol use and peripheral vascular disease. He was experiencing suicidal ideation..." R511's MD progress notes dated September 7, 2023 shows, "Subjective: R511 is seen in follow-up. He and his group of friends were caught with contraband and not following the rules of the facility.... Plan: Certainly, the pain clinic may be able to assist us. I am just uncomfortable continuing to prescribe Opioid if	{S9999}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6008098	A. BUILDING: ______ B. WING ______	R-C 12/20/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROCHELLE GARDENS CARE CENTER	1021 CARON ROAD ROCHELLE, IL 61068

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{S9999}	Continued From page 21	{S9999}		

they are not taken as directed and there are signs of possible misuse of either prescription or recreational drugs..."

On December 14, 2023 at 12:36 PM, V3 (Medical Doctor) stated, he was aware of other times R511 was found intoxicated. R511 had gotten into trouble for drug seeking behavior and then adding alcohol on top of it. He stated, he told him "It was against our advice to get hammered and take prescription medications." R511 was a psych patient with some medical issues. He was primarily at the facility for psych services. V3 agreed that R511 had nowhere else to go because he was homeless.

On December 13, 2023 at 11:59 AM, V6 (RN) stated, she was aware of other times R511 would get intoxicated. R511 and R515 would walk to their counselor's office and on the way back they would stop at the bar and get drunk. Another instance, R511 left to have pizza and came back drunk.

On December 14, 2023 at 9:01 AM, V11 (RN) stated, she was aware of R511 drug seeking and had heard rumors about him being intoxicated at the facility.

On December 13, 2023 at 12:35 PM, V14 (Social Service Director) stated, R511 had no discharge planning. She had not sent any referrals to any other places or helping him find alternative placement. She did not provide any type of alcohol or drug seeking programs for him. R511 went out to a local counseling center but she was unaware of what they worked on there. She only provides groups to the residents 5 days a week for a half hour per day. The topics of the groups are depression, anxiety, PTSD (post-traumatic

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6008098	A. BUILDING: ______ B. WING ______	R-C 12/20/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROCHELLE GARDENS CARE CENTER	1021 CARON ROAD ROCHELLE, IL 61068

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{S9999}	Continued From page 22 stress disorder), anger management and self-esteem. Nurses would do any education with R511 if he needed it. On December 19, 2023 at 11:03 AM, R511 stated, he went to the local counseling center with R515. The facility did not set anything up for him. He "just went with R515." The facility did not do any alcohol or counseling with him while he was there. "I usually just stayed in my room." R511's PASRR (Preadmission Screening and Resident Review) dated September 21, 2023 shows, "Per your documentation you have a history of alcohol dependence, major depressive disorder, recurrent, unspecified and unspecified anxiety disorder. You cannot focus. You forget things often. You worry when you are around others/in social places. You keep to yourself and stay away from others. You have a history of nicotine and alcohol use. PASRR grouping: You fall into the category of having a diagnosis that the PASRR program was designed to assess. Your condition is likely to require expert treatment in the future. That diagnosis is: A serious mental health condition. Rehabilitative services: You will need to be provided the following services and/or supports: ...Crisis intervention services or plan: You could benefit from a crisis plan due to your history of attempting to end your life and harmful behaviors towards others. Individual, group, and family psychotherapy: You would benefit from one-on-one and group therapy due to your worrying and alcohol use, to help learn coping skills process your feelings, troubles, and become more aware of these things. Formal behavior modification program: You have a history of not following rules, you have outburst and have had the police have to get involved during times when you have had these	{S9999}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6008098	A. BUILDING: ______ B. WING ______	R-C 12/20/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROCHELLE GARDENS CARE CENTER	1021 CARON ROAD ROCHELLE, IL 61068

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{S9999}	Continued From page 23	{S9999}		

behaviors..."

R511's care plan only shows the following behaviors: "The resident is non-complaint with smoking rules and safety measures of the facility. 15-minute checks implemented to ensure resident and fire safety along with medication administration compliance. Drug paraphernalia, and smoking materials located in resident's room." His care plan does not address the narcotic drug seeking behaviors, alcohol use, angry outbursts, or other behaviors.

R511's EMR does not show any type of behavior contract or documentation of consequences if behavior continues.

The facility's bed hold guarantee policy (no date) shows, "Upon leaving this facility for admission to a hospital or for a therapeutic leave, a resident shall be guaranteed a bed in this facility upon return if: 1. The resident's condition is such that he/she is appropriate for the level of care provided the facility, and 2. A Medicaid eligible resident was not in the hospital or on leave for more than 10 consecutive days; or 3. The Medicaid resident or responsible party has agreed to pay the Public Aid rate for days excess of the 10 days, or 4. Private pay resident has insured hold on a bed through reimbursement at the current private pay rate... If the facility determines that a resident who was transferred with an expectation of returning to the facility cannot return to the facility, the facility must comply with 42 CFR, Sec 483.15 (c)."

The facility's discharge against medical advice policy (no date) shows, "Policy: It is the policy of the facility to discharge residents only upon written order of the resident's physician.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6008098	A. BUILDING: ______ B. WING ______	R-C 12/20/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROCHELLE GARDENS CARE CENTER	1021 CARON ROAD ROCHELLE, IL 61068

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{S9999}	Continued From page 24	{S9999}		

However, the resident has a right to demand discharge from the facility contrary to their physician's wishes. Procedure: If a resident, or a resident's guardian for healthcare, demands discharge from the facility without the approval of the resident's physician: ...2. The charge nurse must complete the "Nursing Discharge Assessment", 3. The Administrator and the Director of Nursing shall be immediately notified and they shall counsel the resident and/or Power of Attorney for Health Care., 4. A notation must be entered into the resident's record., 5. It is most important that the resident and/or health care guardian sign the "Release of Responsibility for Discharge Against Medical Advice"."

The facility's Transfer and Discharge Policy and Procedure (no date) showed, "It is the policy of [the facility] not to transfer or discharge a resident unless: 1. The transfer or discharge is necessary to meet the resident's welfare, and the resident's welfare cannot be met in the facility..."

"B"