

Illinois Department of Public Health

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 C 02/28/2024
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NAME OF PROVIDER OR SUPPLIER ROCHELLE GARDENS CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1021 CARON ROAD ROCHELLE, IL 61068
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S 000	Initial Comments Complaint Investigation- 2411619/IL170297	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.1010c) 300.1210b) 300.1210d)3) 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 300.1010 Medical Care Policies c) Every resident shall be under the care of a physician. 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	S9999		

Illinois Department of Public Health LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE Electronically Signed	TITLE	(X6) DATE 03/19/24
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S9999	<p>Continued From page 1</p> <p>plan. Adequate and properly supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident.</p> <p>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:</p> <p>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.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on interview and record review the facility failed to obtain physician orders to ensure a resident received his pain medication. This failure resulted in R1 missing 41 days and 123 potential doses and experiencing uncontrolled pain. This applies to 1 of 3 residents (R1) reviewed for pain in the sample of 3.</p> <p>The findings include:</p> <p>R1's face sheet shows he was admitted to the facility on 6/7/23 with diagnoses including chronic embolism and thrombosis of the left lower extremity, bipolar disorder, depression, and chronic pain syndrome.</p> <p>R1's 1/4/24 Minimum Data Set shows he is cognitively intact with no memory impairments.</p>	S9999		

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S9999	<p>Continued From page 2</p> <p>R1's current care plan shows he has chronic pain due to medical conditions including spinal stenosis, and leg pain. Interventions to his care plan show pain medications should be administered as ordered and his physician should be notified of interventions not effective to manage pain. R1's care plan also shows he has a history of polysubstance abuse and drug seeking behaviors.</p> <p>On 2/28/24 at 8:17 AM, R1 said, "I have chronic pain from a previous car accident that caused me to have back surgery and hardware in my back. I also developed blood clots in my left leg and had a stent put in that needs to now be removed. I have a lot of pain to my back and left leg into my groin area. The former Medical Director (V3) stopped seeing me in December and fired me from being his patient. Since then, I had no primary care physician, until yesterday, to prescribe my pain medication that was recommended by the pain clinic in January. The psychiatric Nurse Practitioner (V8) prescribed me Xanax to help with anxiety and withdrawal symptoms when my oxycodone was stopped. I told everyone I could I needed my pain medication ordered and would ask if they found me a new doctor yet, and I would hear from the Administrator (V1) "we are working on it." R1 said "I have pain every day and no pain medication to take beside Tylenol, and that doesn't even touch the pain."</p> <p>A Physician Progress Note for R1 completed by V3 on 12/18/23 with a date of service of 12/7/23 states, "This will be our final visit with (R1). He continues to request more pain medication as, we have told him before, we will cover his pain medication until he is seen by the pain clinic as he and others in the facility had suspected</p>	S9999		

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S9999	<p>Continued From page 3</p> <p>malfeasance with regarding to handling of his pain medication and the medications of others. Although it is not proven, there may have been buying and selling of pain medication as well. Regardless, we tried to discuss this, and unfortunately, this was in a public location. (R1) became extremely agitated and repeatedly told me to, F*** off. He could not be reasoned with and seemed to be relieved that I had informed him I would no longer be providing his care and I did not think we could have a working relationship. We will not be seeing him in person again, I will certainly cover his medical issues until he finds a new physician or 30 days have elapsed."</p> <p>R1's nursing progress notes show the following: 1/4/24- 12:45 PM- Nursing Note shows R1 expressed concerns to V7 (Registered Nurse/RN) that his pain medication no longer had refills. V7 made a pain clinic appointment for R1 for 1/17/24. 1/8/24- 1:11 PM- Nursing Note shows R1 was complaining of body aches, nausea, and anxiety due to his pain medication prescription running out. Orders were received from V8 for Xanax to manage these symptoms.</p> <p>A pain consultation report completed on 1/17/24 by an outside pain management physician for R1 shows R1 has pain rated a 6/10 on the pain scale and described as throbbing and sharp with numbness and tingling. The symptoms worsen when R1 stands, walks, and lays in bed. The report shows R1 has pain from blot clots in his left leg and from a car accident resulting in back surgery in 2022. The recommendations include continue hydrocodone-acetaminophen 10-325 mg 1 tablet by mouth 3 times a day.</p>	S9999		

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S9999	<p>Continued From page 4</p> <p>R1's 1/17/24 Nursing Note shows the facility was aware and documented the recommendation for hydrocodone-acetaminophen to be ordered.</p> <p>R1's January 2024 medication administration record (MAR) shows his last dose of oxycodone-acetaminophen 10-325 milligrams (mg.) was given on 1/7/24. R1's MAR lists the medication is on hold from 1/9/24 through 1/27/24 and discontinued on 1/30/24.</p> <p>R1's February 2024 MAR and Physician Order Summary shows there were no active orders entered for the recommended hydrocodone-acetaminophen (Norco) until 2/27/24.</p> <p>Between 1/17/24 and 2/27/24 when the prescription was sent in for R1's pain medication, 41 days had passed, and he missed out on a possible 123 doses of Norco.</p> <p>On 2/28/24 at 9:20 AM, V5 (Registered Nurse/RN) said it is true that R1 was without a primary care physician (PCP) because V3 booted him and did not re-order his pain medications. V5 said since R1 did not have a new primary care physician there was no doctor to send the prescription for the recommended Norco to obtain the medication for R1. V5 said the facility has a new medical director who sent over the prescription for R1 just yesterday.</p> <p>On 2/28/24 at 9:25 AM, V6 (RN) said the facility administration was very well aware of R1 not having a PCP (Primary Care Physician) to issue the prescription for his pain medication. V6 said R1 complained of pain and constantly asked for his pain medication on schedule around the clock.</p>	S9999		

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S9999	<p>Continued From page 5</p> <p>On 2/28/24 at 10:53 AM, V2 (Director of Nursing/DON) said she has worked at the facility for about a month and was alerted a couple weeks after she started about the issue with R1 not having a PCP to prescribe his pain medication so she called the pain management company to see if they would send the prescription over but they would not order it because they just consult and give recommendations.</p> <p>On 2/28/24 at 11:23 AM, V3 was interviewed by phone and said he stopped seeing R1 due to an issue when R1 became belligerent telling him to F*** off. V3 said he repeatedly told the facility he won't just leave R1 hanging and will re-order his medications until they find him a new PCP within reason. V3 said he does not recall the facility contacting him to order R1's pain medication after his prescription ran out. V3 also said he also would have given the prescription for the pain medication that the pain clinic had recommended had the facility asked him. V3 said unfortunately R1 does have valid pain and will experience lifelong pain and without pain medications his pain level will increase, and withdrawal could happen if the medications are just stopped. V3 said he believes R1 does need the pain medication.</p> <p>On 2/28/24 at 12:50 PM, V1 (Administrator) said V3 is no longer the facility Medical Director. A new Medical Director (V9) took over the care of the residents including R1, and she was able to get him to send the prescription over for R1's pain medication on 2/27/24.</p> <p>On 2/28/24 at 1:45 PM, V7 (RN) said she did try to contact V3 to see if he would re-order R1's pain medication after his prescription ran out. She</p>	S9999		

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S9999	<p>Continued From page 6</p> <p>said she did not contact him after the pain clinic appointment because V3 had made it clear R1 was no longer his patient. V7 said she thinks most of the nursing staff at the facility dismiss R1's pain because they see him as a drug seeker, but she read his medical history and believes his pain is valid and he needs medication for it. V7 said she personally told the facility administration about R1 not having a prescription for his pain medication multiple times.</p> <p>On 2/28/24 at 2:10 PM, V8 (Psychiatric Nurse Practitioner) said she was aware of the concern with R1's pain medication running out because she was contacted about increased anxiety and some withdrawal concerns, so she gave orders for Xanax for these symptoms. V8 said she is not able to prescribe narcotics to residents that needs to be done by his PCP which he did not have at the time.</p> <p>The facility provided Pain Assessment and Management policy revised March 2015 shows the goal of pain management is to develop interventions consistent with the resident needs to help control pain. A physician should establish a treatment regimen and medications should be administered as ordered.</p> <p>"B"</p>	S9999		
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