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
	IL6008114	A. BUILDING: ______ B. WING ______	C 07/26/2023

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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S 000	Initial Comments Complaint Investigation 2315944/IL162192	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.1210b) 300.1210c) 300.1210d)2)3) 300.1220b)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. 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 care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident.	S9999	Attachment A Statement of Licensure Violations	

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

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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 300.1220 Supervision of Nursing Services

b) The DON shall supervise and oversee the nursing services of the facility, including:

3) Developing an up-to-date resident care plan for each resident based on the resident's comprehensive assessment, individual needs and goals to be accomplished, physician's orders, and personal care and nursing needs. Personnel, representing other services such as nursing, activities, dietary, and such other modalities as are ordered by the physician, shall be involved in the preparation of the resident care plan. The plan shall be in writing and shall be reviewed and modified in keeping with the care needed as indicated by the resident's condition.

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S9999	Continued From page 2 These requirements were not met as evidenced by: Based on observation, interview, and record review the facility failed to ensure pain assessments were completed and failed to ensure pain management was provided for 1 of 3 residents (R1) reviewed for pain management in the sample of 9. This failure resulted in R1 experiencing severe pain, anxiety, and restlessness. The findings include: R1's face sheet showed he was admitted to the facility on 7/12/23 with diagnoses to include abdominal aortic aneurysm, diverticulosis of intestine, spondylolisthesis, dependence on supplemental oxygen, and acute and chronic respiratory failure with hypoxia. R1's 7/12/23 Admission/Readmission Nursing Evaluation showed he was alert and oriented to himself only and was admitted to the facility for comfort care. The pain section of R1's admission assessment showed R1 had no complaints of pain at the time of admission and was resting comfortably in his recliner. R1's complete medical record at the facility was reviewed and showed no pain assessments being completed after the initial admission assessment. R1's care plan initiated 7/18/23 showed, "Hospice Services Chosen. [Hospice Provider] to provide psychosocial and nursing supportive support. End stage renal disease process related to failure to thrive, Progressive/Chronic Respiratory Disease... Will express understanding of	S9999		

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S9999	Continued From page 3 condition, remain comfortable as possible, participate in decisions as able and discuss needs/fears... Hospice staff to assess pain/comfort with every visit, staff to assess pain/comfort every shift... Hospice to update staff nurse, CPCs (care plan coordinator) social services regarding any issues/concerns, staff nurse to inform hospice staff for any issues especially areas that compromise comfort. R1's complete current care plan was reviewed and showed no care plan for pain management. R1's Order Administration note dated 7/15/23 showed, "Morphine Sulfate... 0.5 ml by mouth every 1 hour as needed for pain. Crying and complaining of pain." R1's Order Administration note dated 7/22/23 showed, "Morphine Sulfate... 0.5 ml by mouth every 1 hour as needed for pain. Complains of pain all over. Yelling out when being moved." R1's Order Administration note dated 7/24/23 showed, "Morphine Sulfate... 0.75 ml by mouth every 1 hour as needed for pain, The resident is calling out from his bed. He complains of pain when being touched or moved." R1's 7/23/23 nursing note showed, "Resident continues to yell out for most of the shift. PRN (as needed) pain medication given with some effect for short periods of time. Repositioned as resident allows. Combative with staff during cares." On 7/25/23 at 9:31 AM, R1 was lying in his bed. R1 was yelling out that he was hurting. R1 said his side hurts whenever he coughs and he reaches over and holds his right side. R1	S9999		

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continued to cry out in pain.

On 7/25/23 at 11:55 AM, R1 was receiving a bed bath. R1 cried out whenever he was touched to be rolled or change positions. When V4 CNA wiped R1's buttocks he cried out saying, "Please stop it hurts, I must have a very bad rash! Ouch, stop it."

On 7/25/23 at 12:44 PM, R1 was lying in bed and V4 CNA (Certified Nursing Assistant) was assisting him to eat lunch. R1 was calling out that he was hurting. R1 was pulling his gown off and fidgeting continuously. (R1 had received one dose of his PRN pain medication up until this time and that dose had been administered at 5:08 AM when he reported his pain at a 9 out of 10 scale.)

On 7/25/23 at 3:34 PM, V9 (R1's Responsible Party on record) said, "I'm not impressed with this facility. I feel like I'm not getting correct information from them. One nurse tells me he is eating great, drinking great. The next day another nurse called me and said he eats minimally and has dark urine... he has been having long standing pain. He can have his pain medication every hour if he needs it. He can have his lorazepam every 2 hours if he needs it. We called to check on him on either Saturday or Sunday this weekend and the nurse said he was really agitated and that he didn't have much pain medication that day... Last Friday we were in the facility and if I touched him at all he yelled out... [V2] was trying to talk us into a different hospice and said his current hospice company refused to increase his medications. I called the hospice nurse and she said that conversation did not happen and she was happy to talk to the facility about increasing [R1's] medications for comfort. It is my understanding with hospice that we are

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supposed to help keep them comfortable. He is in pain and we need to make sure the pain doesn't get away from him. All I did the day I was in there was touch him and he yelled out 'Don't, it hurts!' He was in pain long before he got here, I'm not saying they caused his pain. What we have is an issue with pain control here. Within a couple of minutes of him receiving his pain medication he was better. I would think you would know he hurts and check on him more often."

R1's July 2023 physician order sheet showed an order dated 7/12/23 for Morphine Sulfate Oral Solution 20 MG/ML, give 0.5 ml by mouth every 1 hour as needed for pain and an order for Morphine Sulfate Oral Solution 20 MG/ML, give 0.75 ml by mouth every 1 hour as needed for pain. In addition to pain medications, R1's July 2023 physician order sheet showed an order for Lorazepam Oral Concentrate 2 MG/ML, give 0.5 ml by mouth every 2 hours as needed for anxiety and Lorazepam Oral Concentrate 2 ML/ML, give 0.75 ml by mouth every 2 hours as needed for anxiety.

R1's Hospice Service nursing documentation entered by an RN (Registered Nurse) on 7/17/23 at 3:00 PM showed, "... Comfort level - complains, "butt hurts"... Oxygen found on the floor - Oxygen saturation on room air 83-86% on 3 liters of oxygen, 99%..."

R1's Hospice Service nursing documented entered by an RN on 7/19/23 at 1:00 PM showed, "... Rates pain at 10/10 to back and toes... Interventions/Treatments completed during visit: talked to nurses regarding pain medications... Comments: ... talked to nurse regarding regular schedule of morphine and lorazepam..."

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R1's Hospice CNA (Certified Nursing Assistant) visit documentation dated 7/19/23 showed a bed bath was given and R1's "butt sore".

R1's Hospice Service nursing documentation entered by an LPN (Licensed Practical Nurse) dated 7/21/23 at 11:25 AM showed, "... Comfort Level. 8/10 pain right hip... Meds given during visit: 0.5 ml of morphine related to right hip pain... facility nurse reports last comfort medications morphine/lorazepam given at 3AM this morning.... Comments: Please note standing orders for morphine every 1 hour as needed ... lorazepam... every 2 hours as needed... Haldol... every 4 hours as needed..."

R1's Hospice Service nursing documentation from a Registered Nurse Visit dated 7/24/23 showed, "... 10:15 AM... Comfort level 10/10 - discussed pain management with staff... Very confused, Oxygen on the floor... Reports significant pain..."

R1's eMAR (electronic Medication Administration Record) for July 2023 showed R1 received his morphine sulfate pain medication on 7/13/23 at 5:48 AM and did not receive another dose until 7/15/23 at 3:17 PM. R1's same MAR showed R1 no documented doses of pain medication from 7/16/23 at 8:42 AM through 7/22/23 at 4:19 AM.

On 7/26/23 at 11:20 AM, V11 (Hospice Nurse) said R1 was on hospice and staying at their hospice house prior to his admission to the facility. V11 said she was in the facility to see R1 last week and the nurse told her he had not received any pain medication since 3:00 AM that day. V11 said R1 was in "horrible" pain. V11 said when he came in the facility from the hospice house, she the facility nurse R1 was getting his

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comfort medications about every 4 hours and appeared comfortable there. V11 said she explained to the facility nurse that if R1 is in pain he should be medicated as their goal through hospice is to keep R1 comfortable. V11 said the same thing goes for the lorazepam for anxiety if R1 is agitated and restless he should be receiving the medications for comfort and relief.

On 7/25/23 at 10:44 AM, V3 LPN (Licensed Practical Nurse) said R1's medications are as needed. V3 said she gave lorazepam and morphine once today. R1's eMAR showed he received that dose of pain medication at 5:08 AM (Approximately 5 hours and 30 minutes before this interview). V3 said R1 says he hurts everywhere. V3 said he pulls on his catheter a lot that makes that hurt. V3 said R1 is very restless, yells out a lot, and takes his clothes off when he is agitated. At 1:50 PM, V3 said R1 had still only received his pain medication one time for the day. V3 said R1's family had just called and was asking if he was receiving his pain medication every hour. V3 said she told them if the CNAs would have reported R1 was having pain when they were in there, she would have given him more pain medication. V3 said the family has asked for his pain medications to be given every hour but the order is for every hour "as needed".

On 7/25/23 at 1:28 PM, V6 CNA (Certified Nursing Assistant) said R1 screams out if you roll him, reposition him, and change his incontinence brief. V6 said R1 frequently complains of back pain.

On 7/25/23 at 12:44 PM, V4 CNA said R1 has complained of pain to his catheter the whole time he has been at the facility. V4 said R1 points to his right side when he coughs and complains of

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pain there too. V4 said R1 complains of pain a lot. We report to the nurse. V4 said after R1 receives pain medication R1 will sleep for about 45 minutes or so and then will be back up yelling out again.

On 7/25/23 at 2:15 PM, V2 DON (Director of Nursing) said she usually goes through the admission documents when resident's come in but she did not look at this one very closely. V2 said she looked at the medications and thought it was strange that he was off his medications aside from his hospice medications such as morphine. V2 said she does not even know how R1 has changed since he has been here because she has not had a chance to look. V2 said when R1 came in the power of attorney's wife pointed at her and said to make sure he gets his medications every four hours or she will see what happens. V2 said last week R1 propelled his wheelchair around the dining room and was threatening to break the windows which was the same behaviors he was having at the hospice house. V2 said she thought it was last Thursday that R1 had a fall. V2 said she called hospice because he was complaining more about stuff and said something about his back hurting. V2 said hospice sent two nurses and they went in and assessed him, came out and said something to the nurse, then just left the building. V2 said she is not a mind reader. V2 said she doesn't even know what the nurses names are that were there and she has not seen any documentation. V2 asked the surveyor if the hospice nurse documented in R1's hospice binder.

The facility's undated policy and procedure titled Comfort Care showed, "Policy: It is the policy of [the facility] to offer Comfort Care to residents when it has been determined by a consensus of

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the resident and/or the resident's family, in consultation with the primary physician and staff caring for the resident, that further aggressive treatment will provide more of a burden to the resident than it will benefit him or her... Purpose: The purpose of this policy is to ensure that all decision made reflect as much as possible the wishes of the individual resident and that all care given recognizes both the sanctity of life and the sanctity of dying as a natural process... Medications will be given as ordered by the physician to alleviate pain and prevent discomfort and restlessness. Both medication options and testing or evaluations will be tailored to the individual circumstances of each resident. Both medication options and testing options will be done after consensus is reached between the physician, resident and or resident's family and the nursing staff... Comfort Measures... 5. Assess for pain, nausea, shortness of breath, fear, and anxiety..."

The facility's policy and procedure with revision date of 12/7/2017 showed, "Pain Prevention and Treatment... Policy: It is the facility policy to assess for, reduce the incidence of and the severity of pain in an effort to minimize further health problems, maximize ADL functioning and enhance quality of life... Responsibility: All nursing personnel... Interdisciplinary Care Team... Procedure: 1. Each resident will be assessed for pain using the Pain Assessment Form including an appropriate Pain Rating Scale upon admission... 2. Assessment of pain will be completed with changes in the resident's condition, self-reporting of pain or evidence of behavioral cues indicative of the presence of pain and documented in the nurses notes or on the Pain Management Flow Sheet. This will include, but is not limited to, date, rating, treatment

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S9999	Continued From page 10 intervention and resident response. 3. The Pain Management Flow Sheet will be initiated for those residents with but not limited to: routine pain medication, daily pain, diagnoses that may anticipate pain..." (B)	S9999		