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	IL6008114	A. BUILDING: _____ B. WING _____	09/05/2024

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ROCK FALLS REHAB & HLTH CARE C	430 MARTIN ROAD ROCK FALLS, IL 61071

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S 000	Initial Comments Annual Health Survey	S 000		
S9999	Final Observations Statement of Licensure Violations 300.610a) 300.1210a) 300.1210b) 300.1210d)1)3) 300.1620a) 300.1630c) 300.1630d) 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 a) Comprehensive Resident Care Plan. A facility, with the participation of the resident and the resident's guardian or representative, as applicable, must develop and implement a	S9999		

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comprehensive care plan for each resident that includes measurable objectives and timetables to meet the resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment, which allow the resident to attain or maintain the highest practicable level of independent functioning, and provide for discharge planning to the least restrictive setting based on the resident's care needs. The assessment shall be developed with the active participation of the resident and the resident's guardian or representative, as applicable. (Section 3-202.2a of the Act)

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.

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:

1) Medications, including oral, rectal, hypodermic, intravenous and intramuscular, shall be properly administered.

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.

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Section 300.1620 Compliance with Licensed Prescriber's Orders

a) All medications shall be given only upon the written, facsimile, or electronic order of a licensed prescriber. The facsimile or electronic order of a licensed prescriber shall be authenticated by the licensed prescriber within 10 calendar days, in accordance with Section 300.1810. All orders shall have the handwritten signature (or unique identifier) of the licensed prescriber. (Rubber stamp signatures are not acceptable.) These medications shall be administered as ordered-by the licensed prescriber and at the designated time.

Section 300.1630 Administration of Medication

c) Medications prescribed for one resident shall not be administered to another resident.

d) If, for any reason, a licensed prescriber's medication order cannot be followed, the licensed prescriber shall be notified as soon as is reasonable, depending upon the situation, and a notation made in the resident's record.

These requirements were not met as evidenced by:

Based on observation, interview and record review the facility failed to ensure a resident with a diagnosis of major depressive disorder received medication to treat the disorder. This failure resulted in R8 having suicidal ideation and being sent to a local emergency room for evaluation. The facility also failed to notify a physician and

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assess a resident (R21) after holding a blood pressure medication. These failures apply to 2 of 2 residents (R8, R21) reviewed for quality of care in the sample of 12.

Findings include:

1. R8's face sheet showed a 79 year old female with diagnosis of major depressive disorder, schizoaffective disorder, bipolar type, generalized anxiety disorder, osteoarthritis, bipolar disorder, hypertension, type 2 diabetes, and chronic obstructive pulmonary disease.

On 9/3/24 at 9:41 AM, R8 was in a wheelchair seated at a dining room table. There was a book in front of her. R8 had clear speech, good eye contact, was calm and in no distress.

On 09/03/24 at 09:41 AM, R8 said "I was hospitalized last week. I felt suicidal. I don't know what they did. They kept me a while and sent me back".

On 09/04/24 at 12:58 PM, V2 Director of Nursing (DON) said "I don't know anything about her fluoxetine (antidepressant medication) running out. I'll have to look into it. The resident could have some type of reaction if they don't get their meds as ordered. They could be very depressed and suicidal".

At 3:00 PM, V16 Director of Nursing at a sister facility said R8's fluoxetine order was left as a pending order. Staff did not know there was a dose increase because of this and R8 did not receive any of the medication for 6 days.

R8's 11/21/23 physician order showed to give fluoxetine (an antidepressant medication) 60

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S9999	Continued From page 4 milligrams (mg) daily. R8's 8/22/24 physician order showed a dose increase of the fluoxetine to 80 mg daily. This order showed the medication was ordered for major depressive disorder and schizoaffective disorder, bipolar type. R8's August 2024 medication administration record (MAR) showed no fluoxetine was administered on 8/25-8/30/24 (6 days). R8's 8/30/24 at 12:19 PM general note showed she stated to multiple people she does not want to live like this anymore. R8's 8/30/24 at 1:16 PM general note showed she was transported to a local hospital for a psychiatric evaluation. R8's 8/31/24 2:26 AM general note showed she was evaluated in the emergency room due to verbalizing she wanted to commit suicide with no plan. R8's care plan showed she had a history of depression and to administer medications as ordered. R8's care plan showed she refuses to wear a brief for incontinence and states that the incontinence makes her feel suicidal at times but has no plan to self-harm. 2. R21's Facesheet dated 9/4/24 showed diagnoses to include, but not limited to: diabetes, Crohn's Disease, COPD (chronic obstructive pulmonary disease), hypertension, major depressive disorder, mild cognitive impairment, and generalize muscle weakness.	S9999		

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On 9/4/24 at 8:38 AM, V3 (LPN - Licensed Practical Nurse) prepared medications for R21. V3 placed R21's lisinopril (blood pressure medication) in a separate medication cup. V3 stated, "I always check the vital signs before I give the blood pressure medications. I don't see any (blood pressure) parameters on the lisinopril, but I know the doctor and they wouldn't want me to give it if the BP is low. V3 gathered the automatic, wrist BP cuff; R21's medications; and the glucometer supplies. V3 obtained R21's BP and it was 99/56. V3 told R21, "I'm not going to give you the lisinopril your blood pressure is too low." V3 did not performed any further assessment on R21. V3 left R21's room and disposed of the lisinopril. V3 documented the reason R21's lisinopril was held was "low BP." R21 did not call the doctor, assess the resident for any changes in condition, or re-check his BP later in the day.

R21's September 2024 MAR (Medication Administration Record) showed an order for lisinopril 10 mg tablet by mouth once a day for HTN (hypertension). This order does not contain parameters for blood pressure and medication administration. On 9/4/23 chart code "9" was entered by V3 (LPN). This documented showed that "9" means "other, see progress notes."

R21's Weights and Vitals Summary dated 9/5/24 showed on 9/3/24 at 8:24 AM, R21's BP was 92/64. This reading was the lowest BP on this report since 10/19/23. There was no blood pressure documented on 9/4/24 (when V3 held the lisinopril). (The blood pressure readings on 9/3/24 and 9/4/24 were both lower than R21's usual blood pressure readings, this trend should have been assessed and monitored by nurse).

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R21's Progress Notes were reviewed. There were no notes regarding R21's low blood pressure, V3 holding R21's lisinopril, notification of the doctor, or follow-up assessments.

On 9/5/24 at 9:05 AM, V2 (DON - Director of Nursing) said lisinopril is a medication for hypertension. V3 said if the doctor wants a medication held, then he would set the vital sign parameters. V2 said if there weren't any blood pressure parameters, then she would re-check the BP and perform an assessment of the resident. The surveyor informed V2 that R21's systolic blood pressure average in the 130-140 range. V2 replied, "Well that would be a change. They should do an assessment, re-check the BP, and continue to monitor. The vital signs should be charted and any follow-up assessments. If the nurse held lisinopril, then she should let the doctor know. He needs to know if the medications aren't given, there may need to be some medication changes made." At 11:30 AM, V2 said she reviewed R21's chart and V3 had not re-checked R21's blood pressure, performed an assessment, or called the doctor. V2 said there isn't a progress note because it wasn't done. V2 stated, "I'll be talking to [V3 - LPN], she should have follow-up with that."

On 9/5/24 at 11:45 AM, the surveyor asked V3 if she had notified the doctor that she held the lisinopril. V3 replied curtly, "Why would I call the doctor for holding that medication? I didn't call the doctor, but I have the numbers in my phone." V3 said she that blood pressure was a little low for R21, but she didn't call the doctor, assess R21, or re-check his blood pressure later in the day (9//24). V3 stated, "I just held the medications because I know what the doctor would say." The

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S9999	Continued From page 7 surveyor asked how a doctor would know if there was a need to changed medications or medication dosages and V3 stared at me blankly and replied, "Well I don't know. There won't be any documentation there because I didn't do any. I guess I should have." The facility's Medication Administration Policy dated 11/18/17 showed, "Drugs and biologicals are administered by physicians and licensed nursing personnel... 22. Notify the physician as soon as practical when a scheduled dose of a medication has not been administered..." (B)	S9999		