STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145221	A. BUILDING _____ B. WING _____	**08/05/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
PARC JOLIET	**222 NORTH HAMMES JOLIET, IL 60435**

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0697 **Level of harm -** Actual harm **Residents Affected -** Few	**Provide safe, appropriate pain management for a resident who requires such services.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to provide physician ordered medications for pain management as prescribed. This applies to 1 of 3 residents (R3) reviewed for pain medications in a sample of 16. This failure has resulted in R3 experiencing exacerbations of pain. Findings include: R3's Admission Records document R3 admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. On 7/23/20 at 10:10 am R3 was observed in his room with the door closed to his room. R3's room was dark, the blinds were closed and R3 had a towel covering the upper portion of his head. R3 stated he was experiencing pain at a 7 but had just taken some pain medications. R3 stated his pain has not been controlled well since admission to the facility because the facility has not been consistently providing his physician ordered pain medications. R3's April and May 2020 Medication Administration Record [REDACTED]. These MAR's document R3 as not receiving 18 doses of [MEDICATION NAME] between April 18 - May 5, 2020 with entries documented in the eMAR Progress Notes (Electronic MAR indicated [REDACTED]. R3's April 2020 MAR indicated [REDACTED]. This MAR indicated [REDACTED]. R3's June 2020 MAR indicated [REDACTED]. This MAR indicated [REDACTED]. R3's June 2020 MAR indicated [REDACTED]. This MAR indicated [REDACTED]. R3's July 2020 MAR indicated [REDACTED]. This MAR indicated [REDACTED]. On 7/29/20 at 3:08 PM V13 (Nurse) stated R3's pain medications were sometimes not available. V13 stated when the medication was not administered R3 would state he would have an increase in his generalized pain and headaches. V13 stated when R3's medications were not available it would be documented on the eMAR. On 7/31/20 at 12:08 PM V12 (Pain Physician) stated it is very important R3's medication regimen is provided as ordered due to progressive Chronic Regional Pai[DIAGNOSES REDACTED] (CRPS) with nerve root issues. R3 receives a combination of [MEDICATION NAME]-[MEDICATION NAME], and [MEDICATION NAME] to manage his pain caused by the CRPS. V12 stated without a consistent pain medication regimen R3's symptoms worsen causing exacerbations of pain. V12 stated he has continued to see V12 regularly with the last visit on 7/8/20. V12 stated since his admission to the facility R3's pain is not as well controlled as it had been prior to admission. V12 stated the facility should be providing the appropriate medication regimen as prescribed to manage R3's pain and prevent exacerbations of uncontrolled pain. R3's Pain Consultation completed by V12 (Pain Physician) dated 7/8/20 documents treating R3 for greater than [AGE] years. V12 documents R3 with development of a [DIAGNOSES REDACTED] (CRPS) that has progressively spread over time to all extremities with an associated chronic neuropathic pai[DIAGNOSES REDACTED] and cervical, [MEDICATION NAME] and lumbosacral symptoms. V12 documents his overall impression for the visit on 7/8/20 as R3 currently has an exacerbation of the [MEDICATION NAME] radicular symptoms due to poor pain management. The facility policy Pain assessment dated ,[DATE] documents to administer pain medication in accordance with the physician order.

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

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.