STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145975	A. BUILDING _____ B. WING _____	**08/07/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
ROCHELLE REHAB & HEALTH CARE CENTER	**900 NORTH 3RD STREET ROCHELLE, IL 61068**

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 0760 **Level of harm -** Actual harm **Residents Affected -** Few	**Ensure that residents are free from significant medication errors.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, and record review, the facility failed to ensure a resident was free of significant medication errors by failing to ensure a resident with an acute infection received an antibiotic as prescribed for 1 of 3 residents (R1) reviewed for infections in the sample of 3. This failure resulted in R1 experiencing a decline in condition and R1's transfer to an acute care hospital where she died on [DATE] of systemic infection. The findings include: R1's facility face sheet showed R1 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. R1's medical record showed R1 was dependent upon staff for all cares and had a feeding tube in place for nutrition. On [DATE] at 1:15 PM, V11 (R1's spouse) said the facility had contacted him to let him know R1 was started on antibiotics to treat a urinary tract infection. V11 said about two weeks later he received a call ([DATE]) from one of the facility nurses who said R1 had a change in condition. The nurse told V11 that R1 was now lethargic, breathing hard, and coughing. V11 said he and his family went to the facility to see R1 and requested the facility send R1 to the hospital for evaluation. She was diagnosed with [REDACTED]. V11 said R1 passed away at the hospital on [DATE]. V11 said if R1 received proper treatment at the facility she wouldn't have [MEDICAL CONDITION]. R1's physician order [REDACTED]. The order showed the antibiotic to be administered two times per day for 10 days. R1's Medication Administration record (MAR) for [DATE] showed the antibiotic was started on the morning of [DATE]. The second dose of antibiotic which was to be given during the evening on [DATE] was not documented as being given. The last dose was given the morning of [DATE] for a total of 7 days (3 days less than prescribed and a total of 6 missed doses). The antibiotic was crossed off of the MAR and a note was written next to it that showed, See N.O. (new order). R1's medical record did not include a new order for an antibiotic or a physician's orders [REDACTED]. On [DATE] at 12;21 PM, V3 LPN (Licensed Practical Nurse) said R1 would normally be combative and verbally aggressive with staff but she had begun staring off into space and was glassy-eyed. V3 said, she improved a little bit when they first started the antibiotic but then it seemed like the antibiotic wasn't doing much. I was not convinced that she was getting better. V3 said if there was a new order written it would be found on the physician order [REDACTED]. V3 said she was unable to find a new order and did not know why the antibiotic was discontinued early. While reviewing the MAR V3 said the handwriting that showed See N.O. appeared to be that of V8 RN (Registered Nurse). On [DATE] at 2:16 PM, V8 RN (Registered Nurse) said he does not remember making any changes to R1's MAR. V8 said R1 was being treated for [REDACTED]. V8 said R1 was more delayed in response then when she first came into the facility. On [DATE] at 2:00 PM, V7 CNA (Certified Nursing Assistant) said she cared for R1 frequently. V7 said before she was sent to the hospital R1 had declined quickly. V7 said R1 was very tired, was not able to speak normally or clearly anymore, had a big decrease in her strength, had decreased urine output, had labored breathing and was started on oxygen. V7 said R1's change in outward appearance was very obvious. On [DATE] at 2:33 PM, V2 DON (Director of Nursing) said she scoured the chart and was not able to find an order to discontinue, or to change the antibiotic. V2 said she contacted the doctor's office to have them fax all the medication changes they have in their records. V2 said R1 was sent out to the hospital for a decline in condition. V2 said if the order is not found on the MAR or the POS we can assume it does not exist. On [DATE], at 11:50 AM, V2 DON (Director of Nursing) said the doctor's office returned her call and there was no order to discontinue the antibiotic and there were no new antibiotic orders to replace the antibiotic that had been stopped. V2 said she feels the antibiotic was erroneously discontinued on [DATE]. On [DATE] at 12:45 AM, a nursing note entered by V9 LPN (Licensed Practical Nurse) showed, Husband (V11) requesting resident to go to (acute care hospital). At 1:55 AM, V9 entered a nursing note which showed, Resident out via ambulance to (acute care hospital). At 5:25 AM, V9 entered another nursing note which showed, Spoke with (acute care hospital), Dx: [MEDICAL CONDITION], dehydration, and UTI (urinary tract infection). On [DATE] at 7:51 AM, V9 LPN said she was the one who sent R1 out to the acute care hospital at the request of the family. V9 said she saw on the MAR that the antibiotic had been crossed out and See N.O. (New Order) but she could not find a new order. V9 said, At that point, the way she was acting I wasn't worried about the order as much as getting her taken care of right away. V9 said she had not seen R1 for about two weeks and this was a big change for her. V9 said R1 was on oxygen and using a lot more muscles for breathing. V9 said, I told her family her breathing is not good and asked them what they wanted to do because her breathing was bad and she wasn't responsibe. I told them she might not make it through the night the way her breathing is . the night I sent her out she was totally not responsive. R1's death certificate with certification date of [DATE] showed R1 died on [DATE] with the cause of her death to be a. worsening metabolic [MEDICAL CONDITION], b. asystole [MEDICAL CONDITION] . R1's acute care hospital Admitting Note dated [DATE] showed, . 1. [MEDICAL CONDITION] - most likely metabolic - due to UTI (Urinary Tract Infection) . 2.[MEDICAL CONDITION] due to UTI - urinalysis suggestive of UTI . 3. Severe [MEDICAL CONDITION] (high sodium level) most likely due to dehydration - patient is on tube feeds . most likely she was not getting free water flushes . 4. Acute respiratory insufficiency - most likely secondary [MEDICAL CONDITION] . On [DATE] at 1:55 PM, V12 (R1's Primary Care Physician) said, I did not write a new order and I didn't discontinue it. The facility keeps all my notes so if I did it would be there. If I order an antibiotic, or, any medication for that matter, for a specific number of days I would expect that medication to be given for that number of days. Usually when ordering an antibiotic we would order for the number of days and then when that's done, if we were to find it wasn't effective or resistant, then we would order something else. The facility's policy titled Conformance with Physician Medication Orders with review date of [DATE] showed, . medications shall be given as prescribed by the physician and at the designated time . 3. A complete and accurate listing of current medication orders will be maintained on the resident's Physician order [REDACTED]. 19. Document any medications not administered for any reason by circling initials and documenting on the back of the MAR the date, the time, the medication and dosage, reason for omission and initials . 22. Notify the physician as soon as practical when a scheduled dose of medication has not been administered for any reason.

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.