

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENTIFICATION NUMBER 145818	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 10/19/2020
NAME OF PROVIDER OF SUPPLIER ROCK RIVER HEALTH CARE		STREET ADDRESS, CITY, STATE, ZIP 707 WEST RIVERSIDE BOULEVARD ROCKFORD, IL 61103	
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 - Minimal harm or potential for actual harm Residents Affected - Few	<p>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 ensure a resident's pain was managed for 1 (R1) of 6 residents reviewed for pain in the sample of 6. The findings include: R1's facility assessment dated [DATE] shows R1 has [DIAGNOSES REDACTED]. R1's Physician order [REDACTED]. On 10/15/2020 at 10:00 AM, R1 was in bed. R1 said she has pain in her shoulder and leg. When R1 was asked to rate her pain 1-10, (1 being the lowest pain and 10 as the worst pain), R1 said her pain rate was 9.5. R1 said she was only given Tylenol for pain. R1 said Tylenol does not help her pain. R1 said she needs a stronger pain medication. On 10/15/2020 at 10:30 AM, V3 (Registered Nurse-RN) said pain scale for 1-5 is moderate pain and 6-10 is severe pain. V3 said R1's rate of pain which is 9.5 shows R1 is in severe pain. V3 said Tylenol does not relieve severe pain. At 10:40 PM, V4 (License Practical Nurse) said R1 needs to be referred to pain clinic. On 10/15/2020 at 11:39 AM, V9 (Certified Nursing Assistant-CNA) said R1 screams in pain when R1 is turned and reposition in bed. At 1:34 PM, V11, V12 and V13 (CNAs) all said R1 complains of leg pain when being moved in bed. Review of R1's pain documentation dated 10/1-15/2020 shows R1 had pain ranged from 6 to 10 pain scale. (severe pain.) R1's Minimum Data Set assessment dated [DATE] under pain assessment interview of R1 shows: R1's pain frequency- constantly. R1's pain intensity-10 (worst pain) And that R1's day to day activities was affected because of her pain. The facility policy on Pain dated 11/2020 shows It is the policy of the facility to facilitate resident independence, promote resident's comfort, preserve and enhance resident dignity and facilitate life involvement. The purpose of this policy is to accomplish that goal through an effective pain management program.</p>		

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.