STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6014989	A. BUILDING: _____ B. WING _____	02/19/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARDEN COURTS OF SOUTH HOLLAND	2045 EAST 170TH STREET SOUTH HOLLAND, IL 60473

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	Initial Comments Annual Licensure Shelter Care Survey	S 000		
S9999	Final Observations Statement of Licensure Violations: 330.1110a) 330.1710b) Section 330.1110 Medical Care Policies a) The facility shall have a written program of medical services approved in writing by the advisory physician that reflects the philosophy of care provided, the policies relating to this and the procedures for implementation of the services. The program shall include the entire complex of services provided by the facility and the arrangements to effect transfer to other facilities as promptly as needed. The written program of medical services shall be followed in the operation of the facility. These Regulations Were Not Met As Evidenced By: Based on observation, interview and record review, the facility failed to administer the prescribed dose of medication ordered by the physician, for one resident (R6) of 8 residents reviewed for medication administration. Findings include: On 2/17/15, at approximately 3:20pm, during evening medication pass with E3 LPN (Licensed Practical Nurse), E3 was observed cutting a pill in half for R6. After the information contained in the	S9999	Attachment A Statement of Licensure Violations	

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S9999	Continued From page 1	S9999		

medication order was scrutinized closely by the surveyor, E3 then reviewed the order, and placed both halves of the pill into the cup to dispense to R6. The physician's order for R6 states "Alprazolam 0.25milligram tablet, Take one tablet by mouth twice daily." E3 indicated that she didn't notice R6 was to receive the entire 0.25milligram tablet. Review of the Controlled Substance Record indicate that the medication nurses have all administered half of the ordered dose of medication (0.125milligrams) to R6 from 1/15/15 to 2/17/15.

E2 DON (Director of Nurses) stated "They (nurses) have been giving R6 half the dose for the last 30 days. I will write an incident report, and notify all the appropriate parties."

Review of the facility policy and procedure for medication pass indicate in the Procedures section "Read the original physician's order: resident's name, medication name, dosage, route and interval ordered. Compare the original physicians medication order with the Medication Observation Record for accuracy."

(C)

Section 330.1710 Resident Record Requirements

b) The facility shall keep an active medical record for each resident. This resident record shall be kept current, complete, legible and available at all times to those personnel authorized by the facility's policies, and to the Department's representatives.

These Regulations Were Not Met As Evidenced

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S9999	Continued From page 2	S9999		

By:

Based on interview and record review the facility failed to maintain current, complete legible records related to falls for three residents (R1,R3,R4) out of five reviewed residents. This deficient practice has the potential to affect all 47 residents in the facility.

Findings include:

R4 was admitted to the facility on 12/14/12 with diagnoses of Alzheimer's, Hypertension, Right Mastectomy, and Goiter. Facility incident reports indicate that R4 had a fall on the following dates; 9/5/14, 9/29/14, /10/29/14, 1/8/15, and 2/12/15.

R4 ' s current care plan in the medical record is dated 3/26/13, and this care plan is without any communication regarding falls. On 2/18/15 at 12:50pm E2 (Director of Nursing) states, " There's no separate care plan for falls, and there should be care plan updates after a fall."

Further review indicates that R3 was admitted to the facility on 3/26/13 with diagnoses of Diabetes, Depression, Hypertension, Dementia, Hypothyroidism, and Osteoarthritis of the knees. Incident report dated 10/11/14 indicates that R3 had a fall and hit the back of her head on the floor. Current care plan in record is without any indication of R3 having a fall. There are no updates on the care plan since 5/18/13.

On 2/18/15 at 1:15pm E1 (Administrator) states, " Care plans are due usually every three months. Multiple falls we talk about them during morning meeting. We determine a plan and we put interventions into place. These interventions

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S9999	Continued From page 3	S9999		

would be in the care plan. Usually my D.O.N. E2 (Director of Nursing) would document these interventions. If R4 falls once every other month or here and there we may not change the care plan. "

R1 was admitted to the facility on 10/16/14 with diagnoses that include Alzheimer ' s disease, Hypertension, and Pain in the lower leg, Syncope and collapse. Review of the facility ' s incident report dated 1/22/15, indicates R1 had a fall during a transfer.

R1 ' s care plan was initiated on 10/26/14. R1 ' s care plan does not have documentation, goals or interventions specifically related to falls.

E1 stated on 2/18/15 at 1:15pm that, " We update the care plan if the resident has had multiple falls. We may not change a care plan if a fall happens only here and there. "

Facility Planning and Monitoring Service Policy revised 8/09 indicate that residents are reassessed within 30 days, and every six months thereafter unless they experience a significant change for better or worse or per state requirement. Service Plans are modified accordingly.

Findings include:

The facility shall keep an active medical record for each resident. This resident record shall be kept current, complete, legible and available at all times to those personnel authorized by the facility's policies, and to the Department's representatives.

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S9999	Continued From page 4	S9999		

Based on interview and record review the facility failed to maintain current, complete legible records related Psychotropic Consents for three residents (R1,R3,R4) out of five reviewed residents. This deficient practice has the potential to affect all 47 residents in the facility.

Review of R4 ' s psychotropic consent for Risperdal 0.25mg is dated 11/12/14. This consent is without a medication frequency being documented. R4 does not have the consent statement documentation being available for this survey. Further review of R3 ' s record is with consent for psychotropic medication therapy for Citalopram 20milligrams, one tablet by mouth daily that ' s without a date. The telephone consent for R3 is dated on 11/5/13 for Citalopram that is without a dose or frequency.

R1 ' s psychotropic consent for Wellbutrin dated 2/3/15 does not contain documentation of a dose or frequency. Review of R1 ' s consent for Escitalopram dated 12/15/14 is without ordered dosage or frequency. R1 ' s statement of consent for Lexapro is without the resident ' s name being documented on the form.

On 2/18/15 at 12:50pm, E2 (Director of Nursing) stated, " Consents should have the name, date, and have a signature on it. The actual dose of the medication is documented on the MAR (Medication Administration Record). I have to check if there ' s a policy on that. "

E2 returned on 2/18/15 at 1:00pm to indicate that there is no written facility policy regarding documentation on psychotropic consents.

(B)