

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6006571	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 03/24/2022
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NAME OF PROVIDER OR SUPPLIER NORRIDGE GARDENS	STREET ADDRESS, CITY, STATE, ZIP CODE 7001 WEST CULLOM NORRIDGE, IL 60634
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S 000	Initial Comments Annual Licensure Survey	S 000		
S9999	<p>Final Observations</p> <p>#1 Statement of Licensure Violations:</p> <p>300.1210b) 300.1610a)1)</p> <p>Section 300.1210 General Requirements for Nursing and Personal Care</p> <p>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.</p> <p>Section 300.1610 Medication Policies and Procedures</p> <p>a) Development of Medication Policies</p> <p>1) Every facility shall adopt written policies and procedures for properly and promptly obtaining, dispensing, administering, returning, and disposing of drugs and medications. These policies and procedures shall be consistent with the Act and this Part and shall be followed by the facility. These policies and procedures shall be in compliance with all applicable federal, State and local laws.</p> <p>This requirement was NOT met as evidenced by:</p>	S9999	<p style="text-align: center;">Attachment A Statement of Licensure Violations</p>	

Illinois Department of Public Health LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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S9999	<p>Continued From page 1</p> <p>Based on observation, interview, and record review, the facility failed to ensure physician-ordered pain medication was available to administer to residents in pain.</p> <p>This applies to 1 of 3 residents (R4) reviewed for pain management.</p> <p>Findings include:</p> <p>On 3/22/22 at 11:40 AM, R4 was on his bed, saying, "My right hip hurts, and I am getting only ibuprofen which is not helpful. I know Norco is very effective for my pain control, and they are not getting me the Norco pill.</p> <p>Record review on physician order sheet (POS) document that R4 can have Norco 10/325 milligram (mg) every six-hours for severe pain.</p> <p>On 3/22/22 at 11:50 AM, R4's medication cart was observed with V5 (Nurse), and no Norco was available for administration.</p> <p>On 3/22/22 at 11:55 AM, V5 stated, "I don't have any Norco available, and I will contact the pharmacy to deliver it.</p> <p>Record review on medication administration record on (MAR) document that no Norco was given to R4 as of 3/22/22.</p> <p>Record review on the facility provided pain management policy revised on 2012 document:</p> <ol style="list-style-type: none"> 1. Pain medication will be given based on the assessment or observation noted on the resident. 2. If the pain medication given to the resident is not effective, then a stronger type of pain medication may be given as ordered by the 	S9999		

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S9999	<p>Continued From page 2</p> <p>physician.</p> <p>(B)</p> <p>#2 Licensure Findings:</p> <p>300.610a) 300.1630a)3) 300.1640a)</p> <p>Section 300.610 Resident Care Policies</p> <p>a) The facility shall have written policies and procedures, governing all services provided by the facility which 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. These policies shall be in compliance with the Act and all rules promulgated thereunder. These written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, as evidenced by written, signed and dated minutes of such a meeting.</p> <p>Section 300.1630 Administration of Medication</p> <p>a) All medications shall be administered only by personnel who are licensed to administer medications, in accordance with their respective licensing requirements. Licensed practical nurses shall have successfully completed a course in pharmacology or have at least one year's full-time supervised experience in administering medications in a health care setting</p>	S9999		

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S9999	<p>Continued From page 3</p> <p>if their duties include administering medications to residents.</p> <p>3) Self-administration of medication shall be permitted only upon the written order of the licensed prescriber.</p> <p>Section 300.1640 Labeling and Storage of Medications</p> <p>a) All medications for all residents shall be properly labeled and stored at, or near, the nurses' station, in a locked cabinet, a locked medication room, or one or more locked mobile medication carts of satisfactory design for such storage. (See subsections (f) and (g) of this Section.)</p> <p>These requirements were NOT met as evidenced by:</p> <p>Based on observation, interview, and record review, the facility failed to: 1. obtain physician orders for resident medication brought from home, 2. obtain physician orders for medications to be at the bedside and 3. complete an self-administration of medication assessment.</p> <p>This applies to 3 out of 3 residents (R3, R10, R11) reviewed for medications in sample of 11.</p> <p>Findings include:</p> <p>On 3/22/22 at 11:05am, initial tour of the 2nd floor was initiated.</p> <p>On 3/22/22 at 11:15am, in R10's room on his bedside table, the following medications were stored: Deep Sea Premium Saline Nasal Moisturizing Spray (1.5 fluid oz-ounces), Artificial</p>	S9999		

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S9999	<p>Continued From page 4</p> <p>Tears Lubricant eye-drops (0.5 fluid oz), and Fluticasone Propionate Salmeterol Diskus inhaler Powder 250mg (milligrams)/ 50mg.</p> <p>R10 was unable to be interviewed. R10's physician order sheet did not document that these medications may be at the bedside. R10's electronic medical record did not have a self-administration of medication assessment form</p> <p>On 3/22/22 at 11:23am, R3 was observed to be in bed. On R3's bedside table the following medications were there: Pepto Bismol Chewables (Bismuth Subsalicylate), Albuterol Sulfate Inhalation 90mcg, and Deep Sea Premium Saline Nasal Moisturizing Spray (1.5 fluid oz). R3 stated, "These medications are always here. The nurse never takes them back. The nurse never showed me how to take them. They never did any assessment on me. I already know how to take them."</p> <p>R3's physician order sheet did not have orders for the medications to be at the bedside. There were no physician orders for the Pepto Bismol Chewables and the nasal spray. There was no self-administration of medication assessment in R3's chart.</p> <p>On 3/23/22 at 9:00 AM, during the medication pass observation, observed R11's bedside table with Breo Ellipta 200-25 microgram inhaler.</p> <p>On 3/23/22 at 9:00 AM, V4 (Nurse) states, "I don't know who left the medication at the bedside. It shouldn't be there."</p> <p>On 3/22/22 at 2:15pm, V2 (Director of Nursing) stated, "You need a physician's order for any</p>	S9999		

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S9999	<p>Continued From page 5</p> <p>medication. You also need an order if resident medications are to be at the bedside. The nurse also has to do a self-administration of medication assessment and see if the resident can safely and properly administer the medications by themselves. Sometimes, families bring medications from home and they don't tell the nurse. It has to be brought to the nurse's attention and she has to reconcile and notify the doctor."</p> <p>Facility's policy titled The Resident's Right to Self-Administer Medications (11/2017) documents: "Procedure: 1. If a resident requests to self-administer the medication, the interdisciplinary team should determine if it is safe for the resident to exercise that right. 2. A resident may self-administer his or her medications meet the following criteria: b. The medication itself is appropriate and safe for self-administrations. e. The resident's cognitive status is not impaired. f. The resident is able to comprehend why and when are the medications to be taken, including dosing, timing, and signs of side effects, and when to report to the facility staff. i. The resident is able to ensure that the medications are stored safely and securely. 3. The interdisciplinary team should document in the resident's medical record result of their assessment, review, and update resident's plan of care if appropriate. 4. If the resident has met the criteria to self-administer his or her medications: If safe storage is not possible in the resident's room, the medications of the residents permitted to self-administer will be stored on a central medication cart or in the medication room. 6. If the staff determines that a resident cannot safely self-administer any medications, the nurse at the facility will administer the resident's medications. 7. The staff shall identify and give</p>	S9999		

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S9999	<p>Continued From page 6</p> <p>to the charge nurse any medications found at the bedside of the resident that are not permitted for bedside storage, for return to the family or responsible party."</p> <p>Facility's policy titled Storage of Medications (November 2015) documents: "2. The nursing staff shall be responsible for maintaining medication storage and preparation areas in a clean, safe, and sanitary manner. 8. Drugs shall be stored in an orderly manner in cabinets, drawers, carts, or automatic dispensing systems. Each resident's medications shall be assigned to an individual cubicle, drawer, or other holding area to prevent the possibility of mixing medications of several residents."</p> <p>(C)</p>	S9999		