STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6008304	A. BUILDING: _____ B. WING _____	03/26/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALDEN TERRACE OF MCHENRY REHAB	803 ROYAL DRIVE MCHENRY, IL 60050

(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 Certification Survey	S 000		
S9999	Final Observations Statement of Licensure Violations: Section 300.1210b) Section 300.3220f) Section 300.1210 General Requirements for Nursing and Personal Care 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. Section 300.3220 Medical Care f) All medical treatment and procedures shall be administered as ordered by a physician. All new physician orders shall be reviewed by the facility's director of nursing or charge nurse designee within 24 hours after such orders have been issued to assure facility compliance with such orders Based on interview and record review the facility failed to ensure a discrepancy with a resident's psychotropic medication was reconciled with a physician upon re-admission after a hospitalization for hypertension for 1 of 31 residents (R137) reviewed for significant medication errors in the sample of 50. This failure resulted in R137 not receiving depakote, which	S9999		

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S9999	Continued From page 1	S9999		

was previously prescribed for aggressive behaviors, to display aggressive behaviors towards another resident and subsequently be sent out to the hospital for an evaluation.

The findings include:

R137's Face Sheet shows that he admitted to the facility on 9/24/24 with diagnoses of: depression, anxiety, history of traumatic brain injury and history of suicidal behavior.

R137's Psychiatric Nurse Practitioner Note dated 10/9/24 shows, "Nursing and staff report moods labile with sarcastic passive aggressive comments at times...He endorses a history of becoming angry and threatening people, states "you don't want to piss me off"; admits to recent feelings of anger with moods up and down at times...I recommend to continue his current medication regimen and start depakote 125 mg (milligrams) bid (twice a day)."

R137's Psychiatric Nurse Practitioner Note dated 12/11/24 shows, "He feels that his moods are generally stable, but he still gets angry more frequently than he believes he should, especially regarding his roommate when they turn on the lights during the night or early morning. An increased dose of depakote to 250 mg p.o (by mouth) twice daily was discussed and patient is agreeable to this change."

R137's Psychiatric Nurse Practitioner Note dated 2/19/25 shows, "Mood and behaviors at baseline. Currently on depakote 250 mg twice daily, which was increased 12/11/24 due to anger management issues, and patient tolerating the dose well. Continue current psychiatric medication regimen including depakote."

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S9999	Continued From page 2	S9999		

R137's Hospital After Visit Summary shows that he was admitted to the hospital from 3/17/25-3/19/25 for hypertension. R137's After Visit Summary does not show that R137 should stop taking depakote nor does it say to start taking depakote.

R137's March Medication Administration Record (MAR) shows that he received depakote 125 mg - two tablets twice a day until 3/17/25. R137 March MAR does not document that he received depakote upon re-admission on 3/19/25 to 3/26/25.

R137's Administration Note dated 3/25/25 shows, "On 3/24/25 at approximately 9:30 AM [R137] stated to this writer that he was very unhappy with his roommate. During the conversation [R137] verbalized signs of aggression involving his roommate. He stated, "If my roommate is still here tonight I'm going to kill him."....he was sent to the hospital for a psych evaluation."

On 3/26/25 at 1:25 PM, R137 said that he does not recall the hospital changing or discontinuing his depakote when he was admitted to the hospital for his high blood pressure.

On 3/26/25 at 1:30 PM, V23 (Physician) said that once a resident re-admits from the hospital, the nurse from the hospital and the nurse from the facility should go over all ordered medications and compare them to their previous medications and if there is a discrepancy, they should discuss the reason for the discrepancy and if they can not figure out why a certain medication is not re-ordered, they should contact the physician or nurse practitioner to get the discrepancy clarified. V23 said, "Especially if it is an important

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S9999	Continued From page 3 medication like this one." B	S9999		