STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6014922	A. BUILDING: _____ B. WING _____	C 01/22/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALDEN ESTATES OF ORLAND PARK	16450 SOUTH 97TH AVENUE ORLAND PARK, IL 60462

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S 000	Initial Comments Complaint Investigations: 1990266/IL108638 - F760G 1990232/IL108604 - F760G	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.1210b) 300.1210c)1)2) 300.3220f) 300.3240a) Section 300.610 Resident Care Policies 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. 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	S9999	**Attachment A** **Statement of Licensure Violations**	

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S9999	Continued From page 1	S9999		

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. Restorative measures shall include, at a minimum, the following procedures:

c) Each direct care-giving staff shall review and be knowledgeable about his or her residents' respective resident care plan.

1) Medications, including oral, rectal, hypodermic, intravenous and intramuscular, shall be properly administered.

2) All treatments and procedures shall be administered as ordered by the physician.

Section 300.1630 Administration of Medication

d) If, for any reason, a licensed prescriber's medication order cannot be followed, the licensed prescriber shall be notified as soon as is reasonable, depending upon the situation and a notation made in the resident's record.

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. (Section 2-104(b) of the Act)

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S9999	Continued From page 2 Section 300.3240 Abuse and Neglect a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. (Section 2-107 of the Act) These Regulations were not met as evidenced by: Based on interviews and record reviews, this facility failed to monitor and assure medications were administered according to physician orders in accordance with accepted professional standards and practices for one resident (R9) prescribed a diabetic medication reviewed for insulin administration. This failure resulted in R9 being admitted to the hospital on 1/10/19 with a critically high blood glucose level. Findings include: Review of the medical record notes R9 was admitted to this facility on 1/8/19 with diagnoses including: diabetes, long term use of insulin, acute and chronic respiratory failure, heart attack, peripheral vascular disease, and acute kidney disease. On 1/18/19 at 4:15pm, V20 RN (registered nurse/clinical support specialist) acknowledged that the nurses are expected to document in the resident's MAR (medication administration record) immediately after any medication is administered, held, or refused. R9's medical record was reviewed with V20. V20 was unable to find any documentation noting R9's blood glucose was checked 1/9/19 at 8:00pm or that R9 received any insulin at that time.	S9999		

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S9999	Continued From page 3	S9999		

On 1/22/19 at 1:00pm, V24 RN stated that V24 worked on the first floor nursing unit on the evening of 1/9/19. V24 stated that R9 was transferred from the second floor to the first floor nursing unit. V24 stated that about 4:00pm, a CNA (certified nurse aide) informed V24 that R9 would be coming some time during V24's shift. V24 stated that at 9:30pm, during end of shift rounds, V24 saw an extra resident in one of the rooms. V24 did not speak with R9 because R9's eyes were closed. V24 stated that V24 was not given report by the nurse transferring R9 or informed when R9 arrived onto the unit. V24 stated that V24 passed to the oncoming nurse to follow up with R9's medications and report from the other nursing unit.

Review of R9's hospital medical record, dated 1/10/19, notes R9 presented to the emergency department at 7:28am. At 7:39am, R9's blood glucose level was 525, critically high (normal value is 70-99). R9's admitting diagnosis was acute hyperglycemia (elevated blood glucose level) with history of diabetes.

Review of R9's POS (physician order sheet), dated 1/8/19, notes the following orders: long acting insulin 35 units subcutaneously at bedtime; before meals and at bedtime administer a fast acting insulin subcutaneously per sliding scale (BG (blood glucose) 201-250 administer 2 units, BG 251-300 administer 4 units, BG 301-350 administer 6 units, BG 351-400 administer 8 units, BG 401-450 administer 10 units, and BG 451-500 administer 12 units and notify physician); and fast acting insulin 15 units subcutaneously three times daily before meals.

Review of R9's MAR (medication administration record), January 2019, notes R9 received one

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S9999	Continued From page 4	S9999		

dose of long acting insulin on 1/8/19. There is no documentation noting R9 received a dose of this insulin on 1/9. There is also no documentation noting R9's blood glucose was checked or received any fast acting insulin at bedtime on 1/9.

Review of R9's care plan, dated 1/9/19, notes R9 has the potential low/high blood glucose reactions secondary to diagnosis of diabetes. Interventions identified include: administer medications for diabetes as ordered, blood glucose monitoring as ordered, monitor for signs of high blood glucose, and monitor for signs of low blood glucose.

Review of R9's blood glucose monitoring results documentation notes on 1/9 at 6:00am R9's blood glucose was documented on the MAR for scheduled fast acting insulin -- 380 and for sliding scale insulin; R9 did not receive the additional 8 units of fast acting insulin per physician order. There is no documentation on 1/9 at 8:00pm noting R9's blood glucose was checked or any fast or long acting insulin was administered.

Review of this facility's medication pass guidelines, dated 06/2014, notes document administration of medication on the resident's MAR immediately after administration. If a medication is refused or held/delayed, document it in an objective manner on the MAR, including the reason for delay or refusal.

(B)