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Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		IL6000814	B. WING			C 25/2015
NAME OF	PROVIDER OR SUPPLIER		DRESS, CITY,	STATE, ZIP CODE		LUILUIU
	IGTON OAKS		ST HEDDING			
	CUMMADVICTA			PROVIDEDIO DI ANI OF CORDECT	101	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
S9999	Final Observations		S9999			OA AA
	Statement of Licens	sure Violations	oo			TO THE PARTY OF TH
	a) The facility shall procedures governing facility. The written be formulated by a Committee consisting administrator, the amedical advisory confined for the written policies shall complements.	dvisory physician or the ommittee, and representatives or services in the facility. The ly with the Act and this Part. shall be followed in operating I be reviewed at least annually documented by written, signed				
	Nursing and Person b) The facility shall pand services to atta practicable physical well-being of the reseach resident's complan. Adequate and care and personal cresident to meet the care needs of the resonal of the research pand of the pand o	provide the necessary care in or maintain the highest I, mental, and psychological sident, in accordance with aprehensive resident care properly supervised nursing care shall be provided to each total nursing and personal		Attachment A Statement of Licensure \		S

Illinois Department of Public Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

04/14/15

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Illinois L	epartment of Public	Health					
	NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	LE CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED	
		IL6000814	B. WING	B. WING		C 03/25/2015	
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY.	STATE, ZIP CODE			
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HEDDING	GTON OAKS	PEORIA, I	IL 61604				
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	and shall be practic seven-day-a-week that it is seven-day-a-week that it is seven-day-a-week that it is seven-day-a-week that is seven-day-a-week that it is seven-day-a-week that is seven-day-a-w						
	Section 300.1630 Administration of Medication b) The facility shall have medication records that shall be used and checked against the licensed prescriber's orders to assure proper administration of medicine to each resident. Medication records shall include or be accompanied by recent photographs or other means of easy, accurate resident identification. Medication records shall contain the resident's name, diagnoses, known allergies, current medications, dosages, directions for use, and, if available, a history of prescription and non-prescription medications taken by the resident during the 30 days prior to admission to the facility.						

Illinois Department of Public Health

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:) DATE SURVEY COMPLETED	
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		IL6000814	B. WING			25/2015	
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY,	STATE, ZIP CODE			
HEDDIN	GTON OAKS	2223 WES PEORIA, I	T HEDDING	AVENUE			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPRIED (CROSS-REFERENCE)	D BE	(X5) COMPLETE DATE	
S9999	Continued From pa	ge 2	S9999				
	not be administered	d to another resident.					
	Section 300.3220 M f) All medical treatmadministered as ordered physician orders shadirector of nursing of within 24 hours after issued to assure factorders. (Section 2-Section 300.3240 Aa) An owner, license agent of a facility shading the section 2. These requirements Based on record refailed to ensure that correct medications (R2) reviewed for madmitted to the host glucose levels and functable blood glucose is sample of glucose levels and functable blood glucose.	Medical Care nent and procedures shall be dered by a physician. All new all be reviewed by the facility's or charge nurse designee or such orders have been cility compliance with such 104(b) of the Act) abuse and Neglect ee, administrator, employee or hall not abuse or neglect a					
	R2 is 94 years old, whypoglycemia, elevatesophageal reflux, seerebral vascular a atrial fibrillation, depreflux disease, and	et dated 2/20/15 documents with diagnosis of drug induced ated cholesterol, hypertension, stricture of esophagus, ecident, diastolic heart failure, pression, gastroesophageal chronic kidney disease.					
R2's nursing notes, dated 3/17/15 at 8:00a.m.				1000			

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Illinois Department of Public Health

STATEMENT OF DEFICIENCIES		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	A. BUILDING:		COMP	LETED
		IL6000814	B. WING		03/2	5/2015
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE	<u> </u>	
			ST HEDDING			
HEDDIN	GTON OAKS	PEORIA, I	L 61604			
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\$9999	written date was 3/2 another resident's referror Incident Report following medication Glucotrol 5mg., Glu 500 mg., Metoprolo 40mg. R2's nursing document Z4 APN of Nurse-contract age R2 receiving the incompact Telephone Order, documents Cardizem CD 180 m for that morning, more check blood sugar at R2's MAR (Medicat dated 3/17/15 (E2 Econfirms date is 3/1 glucose reading was 127/79 at 12:00p.m R2's nurses notes of following blood glucop.m. 60, 2:30 p.m. 47:50p.m. 56, 9:00p. notes dated 3/19/15 glucose readings for 43, 2:27a.m. 41, 3:10 R2's nurses notes of document that Z4 AN urse) was aware of glucose readings.	ate was an error and the actual 18/15), document R2 received medications. R2's Medication ort, dated 3/18/15 identifies the ans as erroneously given to R2: acotrol 10mg., Metformin HCL of Tartrate 25mg., and Lisinopril g notes, dated 3/18/15 (Advanced Practicing ency employee) was notified of correct medication. A lated 3/17/15 (and again, E2 confirms actual date was s Z4 ordered to hold R2's mg. and Carvedilol 3.125 mg. onitor blood pressure and at noon. tion Administration Record) DON, Director of Nursing, 18/15) documents R2's blood as 54 and blood pressure was				
On 3/19/15 at 7:00a.m. R2's nurses notes		a.m. R2's nurses notes				

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STATEMENT OF DEFICIENCIES (X1) PR

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	document that staff motions and would blood pressure was glucose reading 148 regarding R2's condorder documents R2 Room for treatment at 7:20 a.m. R2 was On 3/19//15 R2's nuadmitted to the hosp of blood pressure at R2's Hospital Dischadocuments R2 adm drug induced hypog glucose reading of 2 Summary indicates hours and discharge On 3/24/15 at 11:40 Z3 was present upo Hospital and attende hospitalization. Z3 sof R2 receiving the i have been fatal. Z3 3/19/15 was a direct medications. Z3 sta administered by faci orange juice with sumore unstable. Z3 of the orange juice and R2's pancreas produdecrease R2's blood On 3/24/15 at 12:30 Nursing) stated staff photograph on MAR	noted R2 was having jerking not respond verbally. R2's 192/135, pulse 72, and blood 5. At 7:05a.m. Z4 was notified dition. On 3/19/15 a telephone 2 to be sent to Emergency. Nurses note dated 3/19/15, 3 transferred by ambulance. It is noted to be sent to Emergency are noted ocuments R2 poital for outpatient observation and blood sugar alterations. The Hospital Discharge R2 was monitored for 24 and to the facility on 3/20/15. The Hospital Discharge R2 was monitored for 24 and to the facility on 3/20/15. The Hospital Discharge R2 was monitored for 24 and to the facility on 3/20/15. The Hospital Discharge R2 was monitored for 24 and to the facility on 3/20/15. The Hospital Discharge R2 was monitored for 24 and to the facility on 3/20/15. The Hospital Discharge R2 was monitored for 24 and to the facility on 3/20/15. The Hospital Discharge R2 was monitored for 24 and to the facility on 3/20/15. The Hospital Discharge R2 was monitored for 24 and to the facility on 3/20/15. The Hospital Discharge R2 was monitored for 24 and to the facility on 3/20/15.	S9999			

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IL6000814					03/2	25/2015	
NAME OF I	PROVIDER OR SUPPLIER			STATE, ZIP CODE			
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