STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6015325	A. BUILDING: _____ B. WING _____	04/29/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARDEN COURTS OF PALOS HEIGHTS	7880 WEST COLLEGE DRIVE PALOS HEIGHTS, IL 60463

(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 Survey Complaint Investigation 1591409/IL75751--No findings	S 000		
S9999	Final Observations STATEMENT OF LICENSURE VIOLATIONS Section 330.1520a Administration of Medication All medications taken by residents shall be self-administered, unless administered 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 if their duties include administering medications to residents. This requirement is not met as evidenced by: Based on observation, interview and record review the facility failed to ensure medication was stored properly and administered by the nurse. This applies to 1 resident (R7) in the supplemental sample. The findings include: On 4/27/15 at 10:35am in the Cottage Place living area of the facility, medications for R7 were stored in the cabinet above the sink in the kitchen area. During an interview, E4 (caregiver) and E5 (caregiver) stated they apply the powder and cream under the breast of R7 after showering. At 10:45am, during interview with E3 (Licensed Practice Nurse), she stated that the medication of Nystatin and Clotrimazole 1% cream should be	S9999	**Attachment A** **Statement of Licensure Violations**	

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S9999	Continued From page 1 applied by the nurse and stored in the nursing cart. Un-dated policy titled "Protocol for Administering Medications" states medications shall be prepared, administered and charted by the same person. The procedure stated the medication must be compared with the Medication Observation Record and the medication label for accuracy. For topical medication, assess status of application site (color, odor, drainage, ointment, consistency), temperature, size of area, and complaints of pain/discomfort. Section 330.1530 Labeling and Storage of Medications a) All medications shall be stored in a locked area at all times. Areas shall be well lighted and of sufficient size to permit storage without crowding. This area may be a drawer, cabinet, closet, or room. In those facilities where a licensed nurse dispenses medication to residents, medications may be stored in a locked mobile medication cart, which is made immobile when not in use by the nurse to dispense medication. This requirement is Not Met as evidenced by; Based on observation, interview and record review the facility failed to ensure that medication cart is locked when it is not in direct view of the Nurse administering medication. This applies to 1 of 7 resident (R3) reviewed for medication administration in the sample of 6 and 13 residents (R7, R9, R21-R30) in the supplemental sample. The findings include; On 4/28/2015 at 9:30am, during observation of medication administration, E3 (Nurse) left the medication cart unlocked in the hallway. E3 entered into room 28, 29 and 32 and closed the	S9999		

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S9999	Continued From page 2 door leaving unlocked medication cart in the hallway. On 4/28/2015 at 10:05am, E3 stated she was supposed to lock the medication cart. The facility's undated Protocol titled "Protocol for Administering Medications" under the subheading of "General Instructions" documents " ... Lock the medication storage area when it is not in direct view of the nurse administering medication ..." Section 750.512 When to Wash Hands Food employees shall clean their hands and exposed portions of their arms immediately before engaging in food preparation, including working with exposed food, clean equipment and utensils, and unwrapped single-service articles, and: h) Before donning gloves for working with food; and i) after engaging in other activities that contaminate the hands. This requirement is Not Met as evidenced by; Based on observations and record review the facility failed to ensure staff member wash hands after performing other duties during food service. This has the potential to affect all 12 residents (R2, R10-R20) who resides in the Boat House of the facility. The Findings include: On 4/28/2015 at 12:20pm, during lunch observation, E7 (caregiver) was observed plating foods for the residents in the Boat House. On 4/28/2015 at 12:25pm, E7 walked away from the serving area with gloved hands. E7 reached into her pocket and removed a bunch of keys. E7 handed the keys to another staff member and returned to serving station and continued plating the food for residents. E7 also used gloved hands	S9999		

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S9999	Continued From page 3 to clean food off the counter surface into gloved hands and return to plating food for residents. On 4/28/2015 at about 12:35pm, after plating all resident's food E7 removed gloves and with ungloved hands E7 proceeded to remove saran wrap and then individually wrapped deserts to serve the residents in the Boat House. E7 did not wash her hands after removing gloves and before serving desert to the residents. (B)	S9999		