STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6000640	A. BUILDING: _____ B. WING _____	C 03/12/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LANDMARK OF DES PLAINES REHAB	9300 BALLARD ROAD DES PLAINES, IL 60016

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S 000	Initial Comments Complaint investigations: 2191241/IL131242 2191282/IL131291	S 000		
S9999	Final Observations Statement of Licensure Violations 1 of 2 300.1210b) 300.1210d)3) 300.3240a) 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. d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour, seven-day-a-week basis: 3) Objective observations of changes in a resident's condition, including mental and	S9999	Attachment A Statement of Licensure Violations	

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emotional changes, as a means for analyzing and determining care required and the need for further medical evaluation and treatment shall be made by nursing staff and recorded in the resident's medical record.

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 are not met as evidenced by:

Based on interview and record review, the facility failed to comprehensively assess and recognize a decline in resident condition requiring treatment interventions for 2 of 4 residents (R2, R3) reviewed for change in condition. These failures resulted in R2 becoming non-responsive requiring Emergency Medical Services (EMS) being called and R2 subsequently expiring at the facility and resulted in R3 presenting to the hospital with severe dehydration and hypovolemic shock and expiring in the emergency department.

Findings include:

1. On 3/3/21 at 12:30pm, V22, RT(Respiratory Therapist) stated that there is a respiratory therapist on each nursing unit on the third floor. V22 stated that respiratory therapy is responsible for managing respiratory care for all residents with a tracheostomy and/or ventilator.

On 3/5/2021 at 11:30am, V3, NP(Nurse Practitioner) stated that V6 (Nurse) first attempt to reach V3 was at 5:09am on 12/8/2020. V3

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stated that V3 called the facility at 6:30am when V3 saw message from V6. V3 stated that V6 informed V3 that R2 was stable. V3 stated that V3 instructed V6 to continue monitoring R2. V3 stated that V19 (Nurse) called V3 to inform V3 of R2's second change in condition, instructed V19 to send R2 out 911. V3 stated that R2 coded while waiting for ambulance.

On 3/5/2021 at 1:35pm, V12 (RT) stated that V12 worked on 12/8/2020 7:00am to 7:30pm. V12 stated that V12 does walking rounds with the off-going RT. V12 stated that V12 finished rounds 7:30am-8:00am. V12 stated that V12 told V11(RT) that R2 did not look good; V11 informed V12 that R2's blood pressure was low during the night. V12 stated that she finished rounds then returned to R2's room.

On 3/5/2021 at 1:50pm, V13(RT) stated that if a resident does not look good while doing walking rounds with the off-going RT, V13 will get the resident's nurse and discuss the resident's condition with the nurse and RT. V13 stated that RT should obtain vital signs of resident, blood pressure, pulse, oxygen saturation level. V13 stated that RT should stabilize the resident first before leaving the resident's room to finish getting shift report. When asked what interventions RT should implement for an unstable resident, V13 stated that to stabilize the resident, RT would ventilate resident with bag valve mask to maintain oxygenation at 100%. V13 stated that if resident is still unstable, the resident should be sent out via 911 EMS.

On 3/10/2021 at 11:28am, V18 (EMS paramedic) stated that V18 reviewed V18's report, dated 12/8/2020, and does recall responding to this facility for R2. V18 stated that there was one staff

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member standing in R2's room when EMS entered, but was not touching R2. V18 stated that the staff member informed paramedics that R2's pulse was weak. V18 stated that crew immediately checked for pulse, R2 was pulseless and CPR (cardiopulmonary resuscitation) was initiated immediately by EMS crew. V18 stated that R2's blood sugar level was checked and registered low. V18 stated that staff was asked when the last time R2's blood sugar was checked. Staff informed V18 that R2's blood sugar level was 92 at 5:33am. V18 stated that 6:50am was the last time the nurse stated vital signs were done and documented this in his report. V18 stated that R2's ventilator was not alarming when EMS arrived. V18 stated that when EMS arrived, it did not appear that staff even recognized R2's current condition. V18 stated that the respiratory therapist was not present in room when EMS arrived or while EMS was performing CPR and the crash cart was not in or near R2's room.

Review of V11 (RT) documentation, dated 12/7/2020 at 9:35pm, notes vital signs: heart rate 62 beats/minute, respirations 32/minute, oxygen saturation level 96% on ventilator, lung sounds with rhonchi (coarse breath sounds) throughout all lung fields.

There is no further documentation found by V11 on 12/7/20 or 12/8/20.

Review of R2's progress notes, dated 12/8/2020 at 5:09am, notes R2 awake during care, unable to obtain oxygen saturation level, blood pressure 91/45, heart rate 51 beats/minute, respirations 30/minute, blood sugar level 92, temperature 96.8 degrees Fahrenheit. Message sent to V3 (NP) and V20 (Attending Physician), message marked

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S9999	Continued From page 4 as urgent. On 12/8/2020 at 5:25am, family notified that R2 awake in respiratory distress while receiving care from V11 (RT). Awaiting call back from V3 and/or V20. On 12/8/2020 at 5:54am, V3 and V20 called with message left on R2's status. On 12/8/2020 at 6:23am, V3 returned call, made aware of R2's status, vital signs: heart rate 62 beats/minute, respirations 14/minute, blood pressure 96/58, temperature 96.8. Oxygen saturation 94% via ventilator and tracheotomy. No new orders given at this time. On 12/8/2020 at 7:24pm (time note was written), V19 (Nurse) documented right after report, vital signs: blood pressure 90/54, respirations 14/minute, heart rate 44 beats/minute irregular, temperature 95.9 degrees Fahrenheit, unable to read oxygen. R2 did not respond to painful stimuli, pulse was weak. V20 (Attending Physician) called twice but no response. V3 (NP) called and updated on R2's condition. Order was received to call 911 and send R2 to hospital. R2's family updated on condition and plan of care. 911 called. R2's pulse was becoming weaker. At 7:53-no more pulse palpated. Code blue initiated. 911 crew arrived at 7:55 and CPR continued. At 8:09 R2 was pronounced dead. Review of R2's EMS report, dated 12/8/2020 notes EMS received call at 7:41am, on scene at 7:44am, and at R2's bedside at 7:47am. R2 was without blood pressure, heart rate, or respirations. CPR initiated by paramedics at 7:47am. Crew called to this facility for unresponsive person. Upon arrival, the nurse stated R2's pulse was	S9999		

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weak. During EMS assessment, R2 found to be pulseless, CPR was started and R2 had an existing tracheotomy that paramedics were able to ventilate R2 through. The nurse stated that they last had vitals at 6:50am. R2 remained in asystole throughout the incident. Hospital contacted and crew ordered to stop resuscitative efforts at 8:09am. R2 pronounced expired on scene.

2. Review of the medical record notes R3 with diagnoses including: left femur fracture with routine healing, lack of coordination, dysphagia, dementia, spinal stenosis, hypotension, non-rheumatic aortic stenosis, and cognitive communication deficit.

On 3/5/2021 at 11:05am, V4, CNA (Certified Nurse Aide) stated that when V4 rounded on R3 around 9:00am, R3 did not look good, R3's coloring was off, and R3 was short of breath. V4 stated that V4 notified V7 (Nurse), then proceeded to attend to other assigned residents.

On 3/5/2021 at 11:30am, V3, NP (Nurse Practitioner) denied being informed by nurse on 1/2/2021 of R3's change in condition. V3 stated that V3 was notified on 1/4/21 R3's oxygen saturation level 86% on room air. V3 stated that when V3 arrived to R3's room, V3 called for respiratory therapy to place R3 on oxygen via non-rebreather mask and call 911.

On 3/5/2021 at 2:06pm, V7 (Nurse) stated that V7 provided care for R3 on 1/4/2021. V7 stated that V15 ST (Speech Therapist) informed V7 that R3's pulse was high. V7 stated that V7 went to R3's room and assessed R3, full set of vital signs obtained; V7 stated only R3's pulse was

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abnormal. V7 stated that V7 left R3's room and called V3 (NP). V7 stated that when V3 arrived at R3's room, V3 instructed V7 to notify respiratory therapist. V7 stated that the respiratory therapist came and applied oxygen to R3. V7 stated that V3 instructed V7 to wait 10-15 minutes to see how R3 responds to oxygen therapy before calling 911.
Review of R3's transfer form, dated 1/4/2021 at 12:38pm, V7 (Nurse) noted R3 with shortness of breath, vital signs at 11:50am: blood pressure 90/72, heart rate 149 beats/minute, respirations 26, and oxygen saturation level 86% on room air. V3 (NP) notified at 12:00pm. V3 came to R3's room, called respiratory therapist to put R3 on oxygen with non-rebreather mask. V3 instructed V7 to monitor R3 for 10 minutes and call 911.

On 3/5/2021 at 2:57pm, V15 (ST) stated that on 1/2/21 R3 was exhibiting changes in cognitive status. V15 stated that V15 observed R3 was not as alert as baseline. V15 stated that R3 was lethargic, difficult to arouse, not accepting food. V15 stated that V15 informed V23 (Nurse) of change. V15 stated that if R3's mental status change continued, R3 was at risk for choking on food or liquids. V15 stated that on 1/4/21, R3 appeared the same way, lethargic, not responding. V15 stated that V15 spoke to V7 (Nurse), informed V7 of increased heart rate and shortness of breath.

Review of R3's progress notes, dated 1/2/21 at 10:42am, V23 RN (registered nurse) noted R3 observed pocketing medication and with a gurgling sound while holding medication in his mouth. R3 does not appear to be choking but is not following cue to swallow. Unsafe to administer nectar thicken liquid while medication still in mouth. Head of bed at 90 degrees, bed at

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lowest position with bed mat on the floor. Staff made aware R3 pocketing in mouth and to be very observant for choking. At 12:30pm, V15(ST) approached V23(RN) to inform V23 that R3 was noted with decrease in oral intake. V15 (ST) stated that prior to 12/31/2020, R3 was accepting maximum of 75% of food and fluids by mouth, with the occasional request of additional fluid intake. On 12/31/2020 R3 was observed with a fixated stare, no reaction to staff presence or interaction. V15 ST stated that V15 also noted that R3's food and fluid intake had decreased drastically with R3 pocketing the one spoon of food R3 had accepted. V15 (ST) stated that this is not known as R3's normal behavior. V15 (ST) stated today R3 is noted not to be accepting anything by mouth; food or fluid, and that it is becoming a concern for V15. Mouth care provided, head of bed elevated for choking precaution. At 5:22pm, R3 observed pocketing medication in mouth.

On 1/4/2021, V15 (ST) reported that V15 noted R3 had a pulse of 149. V7 (Nurse) went to R3's room, took R3's vital signs, observed R3's breathing was 24/minute, pulse 149, and oxygen saturation level 86% on room air. V3 (NP) called and notified.

Review of V15's speech therapy treatment encounter, dated 12/31/2020, notes R3 seen at dinner meal. CNA attempted but R3 appeared lethargic and non-verbal. V15 (ST) told CNA to not attempt oral intake at present time as R3 did not appear safe for any food due to lethargy. On 1/2/2021, V15 noted V15 spoke with CNA prior to lunch meal. CNA indicated R3 was lethargic and not very responsive. R3 seen at lunch meal. Elevated head of bed for safety. R3's eyes open but limited responsiveness. R3 eventually

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indicated R3 wanted to eat not attempting to close lips around spoon placement and allowed nectar thick liquids to spill from lips. R3 with severe delayed to potentially absent swallow response. Oral care to remove any remaining food from mouth. R3's head of bed remained elevated. Discussed findings with V23 (RN) who indicated awareness of similar behavior when attempting to give R3 medications. V23 indicated to hold feeding. On 1/4/2021, V15 noted R3 in semi-reclined position in bed. Eyes open and breathing rapidly. R3 not verbally responsive. Informed V7 (Nurse). V15 instructed V4 (CNA) to hold feeding meal.

Review of R3's hospital medical record, dated 1/4/2021 at 1:05pm, notes R3 presented to the emergency department with shortness of breath and worsening altered mental status which began earlier this morning. Physical exam notes R3 is frail, malnourished, ill-appearing, cachetic, tired, and toxic appearing. Coarse breath sounds noted throughout all lung fields. R3's mucous membranes were very dry. R3's heart rate was 120-140s and oxygen saturation level was 95% on 10 liters oxygen via non-rebreather mask, and blood pressure was 99/70. Laboratory results noted sodium level 155 (normal range is 135-145), which is consistent with R3's exam, extremely dry. Kidney function laboratory results noted BUN (blood urea nitrogen) 50 (normal range is 6-20) and creatinine 1.75 (normal range is 0.67-1.17). WBC (white blood cell count) 29.2 (normal range is 4.2-11.0) inflammatory markers elevated. R3's in hypovolemic and septic shock resulting in cardiac arrest. R3 expired in the emergency department.

(A)

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S9999	Continued From page 9 300.610a) 300.1210d)1) 300.1620a) Section 300.610 Resident Care Policies a) The facility shall have written policies and procedures governing all services provided by the facility. The written policies and procedures 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. The policies shall comply with the Act and this Part. The written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, documented by written, signed and dated minutes of the meeting. Section 300.1210 General Requirements for Nursing and Personal Care d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour, seven-day-a-week basis: 1) Medications, including oral, rectal, hypodermic, intravenous and intramuscular, shall be properly administered. Section 300.1620 Compliance with Licensed Prescriber's Orders	S9999		

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S9999	Continued From page 10 a) All medications shall be given only upon the written, facsimile or electronic order of a licensed prescriber. The facsimile or electronic order of a licensed prescriber shall be authenticated by the licensed prescriber within 10 calendar days, in accordance with Section 300.1810. All such orders shall have the handwritten signature (or unique identifier) of the licensed prescriber. (Rubber stamp signatures are not acceptable.) These medications shall be administered as ordered-by the licensed prescriber and at the designated time. These regulations are not met as evidenced by: Based on interview and record review, the facility failed to follow its policies and procedures to prevent a significant medication error for one of three residents (R1) reviewed for significant medication error. This failure resulted in R1 being sent to the local hospital for treatment of a diagnosis of accidental diuretic overdose. The facility also failed to monitor and assure medications were administered according to physician orders in accordance with accepted professional standards and practices for 4 of 5 residents (R1, R5, R14, and R17) receiving medication for low blood pressure in a sample of 27. Findings include: 1. Review of the medical record notes R1 with diagnoses including: acute respiratory failure, heart failure, supraventricular tachycardia, hypothyroidism, muscular dystrophy, adrenocortical insufficiency, tracheostomy, ventilator dependent, dysphagia, generalized muscle weakness, myopia, presbyopia, major	S9999		

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depressive disorder, and anxiety disorder.

Review of R1's POS (physician order sheet), dated 9/11/2020, notes an order for Furosemide 8mg/ml (milliliter), Furosemide 10mg/ml supplied. Take 1.25ml (12.5mg) by mouth daily. On 10/23/2020, notes an order for Midodrine 5mg oral in the morning for hypotension, hold if SBP (systolic blood pressure) is more than 120. On 2/25/2021, notes Midodrine was increased to 5mg oral three times a day, hold if SBP is more than 120.

Review of R1's MAR (medication administration record), dated February 2021, notes R1 received Midodrine 5mg on 2/7 for BP (blood pressure) 123/76; on 2/10 for BP 133/80, on 2/16 for BP 122/69, on 2/17 for BP 132/74, on 2/20 for BP 124/76, on 2/27 at 9:00am for BP 137/76, on 2/27 at 2:00pm for BP 136/75, on 2/27 at 9:00pm for BP 132/70, and on 2/28 at 9:00pm for BP 128/71.

Review of R1's MAR, dated March 2021, notes R1 received Midodrine on 3/1 at 9:00pm for BP 130/76, on 3/2 at 9:00am for BP 129/71, on 3/2 at 9:00pm for BP 121/65, on 3/3 at 9:00pm for BP 133/69, on 3/4 at 9:00am for BP 122/56, on 3/4 at 9:00pm for BP 122/74, on 3/6 at 9:00am for BP 150/69, and on 3/7 at 9am for BP 132/68.

On 3/4/2021 at 9:40am, R1 stated that R1 questioned the nurse regarding the dosage of the Lasix (brand name for Furosemide a diuretic) because the amount of the liquid was more than R1 routinely takes. R1 stated that the nurse informed R1 the dosage was 12.5mg (milligrams). R1 stated that this is the usual dose so R1 took the medication. R1 stated that afterwards, the nurse returned to R1's room and informed R1 that R1 was given 125mg Lasix

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S9999	Continued From page 12	S9999		

instead of the prescribed dose of 12.5mg. R1 stated that R1 was sent to the hospital for monitoring.

Review of R1's progress notes, dated 2/23/2021 at 9:22am, V14, RN (registered nurse), noted during the morning medication pass, V14 gave incorrect dose of Furosemide 10mg/ml oral solution. The order is for 1.25ml/ 12.5mg dose in morning. V14 poured 12.5 ml and gave to R1. R1 asked how much that dose was. V14 explained 12.5 mg was given. V14 left room to recheck the order from the electronic medical record and the bottle, it was to be 1.25ml given. Notified V16 (former Director of Nursing) immediately, V16 ordered to send to hospital via 911. R1's vital signs: blood pressure 122/67, heart rate 54 beats/minute, oxygen saturation level 96%. V14 explained to R1 the situation regarding the Furosemide and the need to send R1 to the hospital. Then V14 called 911, and R1 was sent to the hospital.

Review of R1's hospital medical record, dated 2/23/2021, R2 was admitted with diagnosis of accidental Furosemide overdose. R1's respiratory assessment in the emergency room notes crackles noted in all lobes. On two occasions during hospital stay, R1's blood pressure decreased to 76/61 at 12:18am and then to 77/59 at 3:11am, requiring medication and intravenous fluids to improve blood pressure. R1's laboratory results for kidney function: BUN (blood urea nitrogen) was 27 (normal range is 6-20) on 2/23 and 40 on 2/24; creatinine was 0.17 (normal range is 0.51-0.95) on 2/23 and 0.25 on 2/24. Sodium level was 138 (normal range is 135-145) on 2/23 and 136 on 2/24. Magnesium level was 1.9 (normal range is 1.7-2.4) on 2/23 and 1.8 on 2/24. Potassium level was 4.3

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6000640	A. BUILDING: _____ B. WING _____	C 03/12/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LANDMARK OF DES PLAINES REHAB	9300 BALLARD ROAD DES PLAINES, IL 60016

(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
S9999	Continued From page 13 (normal range is 3.4-5.1) on 2/23 and 4.4 on 2/24. On 3/5/2021 at 11:30am, V3 NP (Nurse Practitioner) stated that the nurse called V3 at home. V3 stated that V3 instructed the nurse to send R1 to the hospital 911 when informed R1 received 125mg instead of 12.5mg of Furosemide. V3 stated that R1 required additional monitoring of electrolytes, sodium, magnesium, and potassium, as well as vital sign monitoring. V3 stated that R1's kidneys are functioning well and the medication will clear out of R1's system within days. V3 stated that it is not good for a resident to receive 125mg of Furosemide; there is potential for negative side effects. V3 stated that Midodrine is administered to residents with low blood pressure to increase their blood pressure. V3 stated that when this medication is prescribed, there are parameters for when to hold this medication. V3 stated that it is not good to be administering this medication when the resident's blood pressure is outside of these parameters, because it causes an increase in the resident's blood pressure even further. Review of this facility's medication administration procedure, updated 6/19/2012, notes to remove medication from drawer, read each label carefully: when removing from drawer, before pouring, and after pouring. Pour each dose of medication using an appropriate measuring device. 2. Review of R5's medical record notes R5 with diagnoses including: hypertensive heart disease and chronic kidney disease with heart failure, atrial fibrillation, dependence on renal dialysis, coronary artery disease, and diabetes. Review of R5's POS, dated 2/13/2021, notes an	S9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6000640	A. BUILDING: _____ B. WING _____	C 03/12/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LANDMARK OF DES PLAINES REHAB	9300 BALLARD ROAD DES PLAINES, IL 60016

(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
S9999	Continued From page 14 order for Midodrine 10mg oral three times a day for hypotension, hold if SBP above 100. Review of R5's MAR, dated March 2021, notes R5 received Midodrine on 3/1 at 9:00am for BP 145/69, on 3/1 at 9:00pm for BP 125/76, on 3/2 at 9:00am for BP 121/78, on 3/2 at 2:00pm for BP 121/78, on 3/2 at 9:00pm for BP 126/79, on 3/3 at 2:00pm for BP 108/46, on 3/4 at 9:00am for BP 129/82, on 3/4 at 2:00pm for BP 133/73, on 3/4 at 9:00pm for BP 125/81, on 3/5 at 9:00am for BP 125/75, on 3/5 at 2:00pm for BP 125/75, on 3/6 at 9:00am for BP 121/63, on 3/7 at 9:00pm for BP 127/78, on 3/11 at 9:00am for BP 124/79, and on 3/11 at 2:00pm for BP 124/79. 3. Review of R14's medical record notes R14 with diagnoses including: diabetes, chronic kidney disease-stage 3, hypotension, anemia, shortness of breath, and dependence on oxygen. Review of R14's POS, dated 1/6/2021, notes an order for Midodrine 2.5mg oral three times a day for hypotension. Review of R14's MAR, dated March 2021, notes R14 received Midodrine on 3/6 at 9:00am for BP 139/69, on 3/6 at 2:00pm for BP 139/69,on 3/6 at 9:00pm for BP 130/70, on 3/7 at 9:00am for BP134/72, on 3/7 at 2:00pm for BP 134/72, and on 3/7 at 9:00pm for BP 132/64. 4. Review of R17's medical record notes R17 with diagnoses including: respiratory failure, tracheostomy, dependence on oxygen, anemia, atrial fibrillation, weakness, and stroke. Review of R17's POS, dated 6/20/2020, notes an	S9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6000640	A. BUILDING: _____ B. WING _____	C 03/12/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LANDMARK OF DES PLAINES REHAB	9300 BALLARD ROAD DES PLAINES, IL 60016

(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
S9999	Continued From page 15 order for Midodrine 5mg oral every 12 hours for hypotension, hold if SBP above 100. Review of R17's MAR, dated March 2021, notes R17 received Midodrine on 3/1 at 9:00pm for BP 132/88, on 3/2 at 9:00am for BP 115/69, on 3/2 at 9:00pm for BP 115/69, on 3/3 at 9:00am for BP 107/77, on 3/3 at 9:00pm for BP 121/56, on 3/4 at 9:00am for BP 112/74, on 3/4 at 9:00pm for BP 111/71, on 3/5 at 9:00pm for BP 111/69, on 3/7 at 9:00pm for BP 126/78, on 3/8 at 9:00pm for BP 125/76, and on 3/11 at 9:00am for BP 118/62. Per Medline plus website, Midodrine medication is used to treat low blood pressure at rest. It is in a class of medications that cause blood vessels to tighten which increases blood pressure. Per the FDA (Food and Drug Administration) website, Midodrine can cause a marked increase in blood pressure at rest. The most potentially serious adverse reaction associated with midodrine therapy is high blood pressure at rest. (A)	S9999		