Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6007876	A. BUILDING: ______ B. WING ______	03/30/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DOWNERS GROVE REHAB & NURSING	3450 SARATOGA AVENUE DOWNERS GROVE, IL 60515

(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 Second Probationary Licensure Survey	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610a) 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 300.1620 Compliance with Licensed Prescriber's Orders 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 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	S9999	Attachment A Statement of Licensure Violations	

Illinois Department of Public Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

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the licensed prescriber and at the designated time.

This REQUIREMENT was not met as evidenced by:

Based on observation, interview, and record review, the facility failed to administer medications as ordered by a physician resulting in a 48% medication error rate.

This applies to 5 of 5 residents (R3, R5, R6, R7, R8) reviewed during the medication pass in the sample of 8.

The findings include:

1) R3's electronic face sheet printed on 3/30/23 showed R3 has diagnoses including but not limited to chronic kidney disease, major depressive disorder, retention of urine, and heart failure.

R3's medication administration record (MAR) for March 2023 showed R3 is to receive Torsemide 10mg daily beginning 3/29/23 for congestive heart failure. R3's medication record showed R3 did not receive his Torsemide on 3/29/23.

On 3/30/23 at 9:58AM, V3 (Registered Nurse) was preparing R3's medications. V3 was unable to locate R3's Torsemide in the medication cart or in the facility's convenience medication system. V3 stated she would have another nurse call the pharmacy to ensure the medication would be delivered. V3 confirmed R3 did not receive his Torsemide on 3/29/23 as it was documented as "not available" on R3's medication administration record.

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S9999	Continued From page 2 The facility's policy titled, "General Guidelines for Medication Administration" with a revision date of 08/2020 showed, "Medications are administered as prescribed in accordance with good nursing principles and practices and only by persons legally authorized to administer. Personnel authorized to administer medications do so only after they have been properly oriented to the facility's medication distribution system (procurement, storage, handling, and administration). The facility has sufficient staff and a medication distribution system to ensure safe administration of medications without unnecessary interruptions...5. Always employ the MAR during medication administration. Prior to the administration of any medication, the medication and dosage schedule on the resident's MAR are compared with the medication label...II. Administration...2. Medications are administered in accordance with written orders of the prescriber." 2) R5's electronic face sheet printed on 3/30/23 showed R5 has diagnoses including but not limited to fracture of right ischium, dementia without behaviors, pneumonia, and retention of urine. R5's MAR for March 2023 showed R5 is to receive Cephalexin 250mg at 9AM, 2PM, and 9PM and Saccharomyces 250mg in the AM medication pass (7am-10am) and the PM medication pass. On 3/30/23 at 11:10AM, V3 administered R5's Cephalexin 250mg and Saccharomyces 250mg. (R5's Cephalexin was given 2 hours and 10 minutes past administration time and Saccharomyces was given 1 hour and 10 minutes past administration time).	S9999		

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3) R6's electronic face sheet printed on 3/30/23 showed R6 has diagnoses including but not limited to orthostatic hypotension, anxiety disorder, hypertension, history of pulmonary embolism, and major depressive disorder.

R6's MAR for March 2023 showed R6 is to receive amlodipine 2.5mg, apixaban 2.5mg, carvedilol 25mg, clonidine 0.2mg, oxybutynin 10mg, venlafaxine 75mg, torsemide 20mg, and sodium bicarbonate 1,300mg between 7am-10am. R6 is to receive hydralazine 100mg at 12am, 8am, and 4pm.

On 3/30/23 at 11:39AM, V3 was preparing R6's medications and placed one 650mg tablet of Sodium Bicarbonate into the medication cup for R6. V3 stated R6 only gets one tablet of sodium bicarbonate. Surveyor requested V3 to re-evaluate the order and V3 then stated, "Oh, I guess she gets two tabs. I didn't see that. V3 then administered R6's amlodipine 2.5mg, carvedilol 25mg, clonidine 0.2mg, oxybutynin 10mg, venlafaxine 75mg, and sodium bicarbonate 1,300mg. V3 was unable to locate R6's apixaban 2.5mg and torsemide 20mg. (R6's hydralazine was administered 2 hours and 4 minutes late, while all other medications given at this time were 1 hour and 40 minutes late).

4) R7's electronic face sheet printed on 3/30/23 showed R7 has diagnoses including but not limited to type 2 diabetes, cerebral infarction, and history of venous thrombosis and embolism.

R7's MAR for March 2023 showed R7 is to receive Allopurinol 100mg at 8am.

On 3/30/23 at 9:46AM, V3 was preparing R7's

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medications. V3 removed two 100 mg Allopurinol tabs and placed them in the medication cup for administration to R7. V3 began entering R7's room when surveyor asked V3 to check R7's medications at which point she identified that an extra 100mg Allopurinol tablet was present in the medication cup and removed it. V3 stated, "Sometimes when I pop out medications, 2 of them come out and I don't realize it. This would have been a medication error if you wouldn't have caught it. All medications should be given within 1 hour before or 1 hour after administration time or else it would be considered a medication error."

5) R8's electronic face sheet printed on 3/30/23 showed R8 has diagnoses including but not limited to rheumatoid arthritis, chronic kidney disease stage 3, hypertension, and kidney transplant status.

R8's MAR for March 2023 showed R8 is to receive Carvedilol 25mg between 7-10am. R8's MAR also showed R8 is to receive hydroxychloroquine 200mg, mycophenolate 250mg, and tacrolimus 1mg at 9am.

On 3/30/23 at 10:56AM, V3 administered R8's hydroxychloroquine 200mg, mycophenolate 250mg, and tacrolimus 1mg. (1 hour and 56 minutes late).

(B)