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
	IL6015424	A. BUILDING: ______ B. WING ______	C 08/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARDEN COURTS (GENEVA)	2388 BRICHER ROAD GENEVA, IL 60134

(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 Facility reported incident survey of 7/9/2024/ IL175516	S 000		
S9999	Final Observations Statement of Licensure Violations TITLE 77: PUBLIC HEALTH CHAPTER I: DEPARTMENT OF PUBLIC HEALTH SUBCHAPTER c: LONG-TERM CARE FACILITIES PART 330 SHELTERED CARE FACILITIES CODE SECTION 330.1510 MEDICATION POLICIES Section 330.1510 Medication Policies a) Every facility shall adopt written policies and procedures for assisting residents in obtaining individually prescribed medication for self-administration and for disposing of medications prescribed by the attending physicians. These policies and procedures shall be consistent with the Act and this Part and shall be followed by the facility. Based on interview and record review the facility failed to administer a Physician ordered medications as prescribed and failed to folllow their policy for medication guidelines. This applies to one of three residents (R1) reviewed for medications in the sample of three. The findings include: The July 2024 Physician Orders Sheet (POS) for R1 shows diagnoses to include dementia, hearing	S9999		

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

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S9999	Continued From page 1 loss, depression, anxiety, hypertension and Diabetes Mellitus Type 2. The POS shows an order for Trulicity (anti-diabetic medication) 1.5mg/0.5ml pen, inject 1.5 mg sub-q (beneath the skin) weekly (Monday) for Type 2 Diabetes Mellitus. The Medication Administration Record (MAR) for July 2024 shows R1 received her Trulicity on July 8, 2024 and then again on July 9,2024. The nursing progress notes dated 7/10/24 for R1 shows Trulicity was given on 7/8/24 and then again a day later on 7/9/24 by another nurse. On 8/10/24 at 10:30 AM, V3 and V4 both Licensed Practical Nurses (LPN) said medications should be given as ordered by the Physician and must be reported to the facility, to the Physician and the family if a medication error occurres. The resident must be monitored after an error happens. On 8/10/24 at 10:00AM, V1 Administrator and V2 Director of Nursing said they were notifed by a nurse working the floor on 7/10/24 around 5:30 AM that R1 had received two doses of her Trulicity, once on 7/8/24 and a dose on 7/9/24. The nurse that had given the second dose was identifed as V5 Agency LPN. Attempts were made to contact V5, but she never returned our calls. The nursing staff are expected to give the medications as ordered, report any errors and follow the polices of the facility for medication administration. The facility policy dated 6/2021 for Medication and Treatment Guidelines shows medications are administered in accordance with standards of practice and state specific and federal guidelines. Medciation errors are documented in the incident	S9999		

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S9999	Continued From page 2 management system. Medications are administered in accordance with the following rights of medication administration: right resident, right medication, right dose, right route, right time, right documentation, right of resident to refuse and right clinical indication. (B)	S9999		