STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146069	A. BUILDING _____ B. WING _____	C 05/20/2005

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVER VIEW MANOR, LTD	**6131 PARK RIDGE ROAD LOVES PARK, IL 61111**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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) COMPLETION DATE
F9999	Continued From page 37	F9999		
F9999	FINAL OBSERVATIONS STATE VIOLATIONS ASSOCIATED WITH COMPLAINTS #0511654 & # 0511822 300.610 a) 300.1010 h) 300.1210 a) 300.1210 b) 300.1210b)1) 300.1210 b) 2) 300.1210 b) 3) 300.1210 b) 6) 300.1220 b) 300.1220b)1) 300.1220b)3) 300.1220b)6) 300.1220b)8) 300.1630 b) 300.1630 e) 300.1810g) 300.1810h) The facility shall have written policies and procedures, governing all services provided by the facility which 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. These policies shall be in compliance with the Act and all rules promulgated there under. These written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, as evidenced by	F9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146069	A. BUILDING _____ B. WING _____	C 05/20/2005

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVER VIEW MANOR, LTD	**6131 PARK RIDGE ROAD LOVES PARK, IL 61111**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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) COMPLETION DATE
F9999	Continued From page 38 written, signed and dated minutes of such a meeting. Facility staff shall notify the resident¿s physician of any accident, injury, or significant change in a resident¿s condition that threatens the health, safety or welfare of a resident, including, but not limited to, the presence of incipient or manifest decubitus ulcers or a weight loss or gain of five percent or more within a period of 30 days. The facility shall obtain and record the physician¿s plan of care for the care or treatment of such accident, injury or change in condition at the time of notification. The facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of the resident, in accordance with each resident¿s comprehensive assessment and plan of care. 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. Personal Care, as defined in section 300.330, is assistance with meals, dressing, movement, bathing or other personal needs or maintenance, or general supervision and oversight of the physical and mental well-being of an individual who is incapable of maintaining a private, independent residence or who is incapable of managing his person, whether or not a guardian has been appointed for such individual (Section 1 -120 of the Act) General nursing care shall include at a minimum the following and shall be practiced on a 24-hour, seven day a week basis:	F9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146069	A. BUILDING _____ B. WING _____	C 05/20/2005

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVER VIEW MANOR, LTD	**6131 PARK RIDGE ROAD LOVES PARK, IL 61111**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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) COMPLETION DATE
F9999	Continued From page 39 · Medications including oral, rectal, hypodermic, intravenous, and intramuscular shall be properly administered. · All treatments and procedures shall be administered as ordered by the physician. · Objective observations of changes in a resident¿s condition, including mental and 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. · All necessary precautions shall be taken to assure that the residents¿ environment remains as free of accident hazards as possible. All nursing personnel shall evaluate residents to see that each resident receives adequate supervision and assistance to prevent accidents. The DON shall supervise and oversee the nursing services of the facility, including: · Assigning and directing the activities of nursing service personnel. · Developing an up-to-date resident care plan for each resident based on the resident¿s comprehensive assessment, individual needs and goals to be accomplished, physician¿s orders, and personal care and nursing needs. Personnel representing other services such as nursing, activities, dietary, and such other modalities as are ordered by the physician shall be involved in the preparation of the resident care plan. The plan shall be in writing and shall be reviewed and modified in keeping with the care needed as indicated by the resident¿s condition. The plan shall be reviewed at least every three months. · Developing and maintaining nursing service	F9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146069	A. BUILDING _____ B. WING _____	C 05/20/2005

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVER VIEW MANOR, LTD	**6131 PARK RIDGE ROAD LOVES PARK, IL 61111**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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) COMPLETION DATE
F9999	Continued From page 40	F9999		

objectives, standards of nursing practice, written policies and procedures, and written job descriptions for each level of nursing personnel.

· Supervising and overseeing in-service education, embracing orientation, skill training, and on-going education for all personnel and covering all aspects of resident care and programming. The educational program shall include training and practice in activities and restorative/rehabilitative nursing techniques through out-of-facility training programs. This person may conduct these programs personally or see that they are carried out.

The facility shall have medication records which shall be used and checked against the physician ¿s orders to assure proper administration of medicine to each resident. Such records as computer generated medication sheets may be used. Medication records shall include or be accompanied by recent photographs or other means of easy identification such as resident identification wristbands. Medication records shall contain the resident¿s name, diagnoses, non-prescription medications taken by the resident during the 30 days prior to admission to the facility.

Medication errors and drug reactions shall be immediately reported to the resident¿s physician and the consultant pharmacist. An entry thereof shall be made in the resident¿s clinical record and the error or reaction shall also be described in an incident report.

A medication administration record shall be maintained, which contains the date and time each medication is given, name of drug, dosage,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146069	A. BUILDING _____ B. WING _____	C 05/20/2005

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVER VIEW MANOR, LTD	**6131 PARK RIDGE ROAD LOVES PARK, IL 61111**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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) COMPLETION DATE
F9999	Continued From page 41 and by whom administered. Treatment sheets shall be maintained recording all resident care procedures ordered by each resident¿s attending physician. Physician ordered procedures that shall be recorded include, but are not limited to, the prevention and treatment of decubitus ulcers, weight monitoring to determine a resident¿s weight loss or gain, catheter/ostomy care, blood pressure monitoring, and fluid intake and output. These regulations were not followed based on record review and interviews, which substantiated that the facility failed: 1. To develop a comprehensive care plan for 2 residents in the areas of: · care of a PICC line, · wound care and treatments · diabetic care for resident's with Diabetes Mellitus/hypoglycemic reaction, · bucks traction, · supervision and monitoring to prevent falls, · balance training, · physical assistance during activities, · dressing application, and · performing glucose monitoring tests. 2. To provide services that meet professional standards in the areas of: · providing glucose sources when a resident has a hypoglycemic event, · rechecking glucose levels after a hypoglycemic event, · instructing a resident to remain in bed when glucose levels are low · notifying the physician of low glucose levels (below 60). 3. Provide the necessary care and services to	F9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146069	A. BUILDING _____ B. WING _____	C 05/20/2005

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVER VIEW MANOR, LTD	**6131 PARK RIDGE ROAD LOVES PARK, IL 61111**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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) COMPLETION DATE
F9999	Continued From page 42	F9999		

residents in the following areas by not:
· having a system in place to orient new nurses and agency nurses to facility practices on medication administration,
· having a means to accuracy identify residents for providing medications and treatments,
· administering medications accurately,
· responding to a resident having a hypoglycemic reaction,
· monitoring blood sugars, as ordered,
· notifying physician of low blood glucose levels,

This is for 2 of 3 sampled residents (R1, R2) and 7 off sample residents. Findings include:

Example 1:
R1's resident assessment dated 4/8/2005 assessed R1 as having no memory deficits and no cognitive impairments. R1 was assessed as being in need of "Monitoring acute medical condition", as having no behavior problems, and of having limitations on both sides of his body in his legs and feet. R1's medication administration records (MAR) dated 3/2005 and 4/2005 identify physician's orders for "{blood glucose checks} BID", and to call the physician if the glucose reading is "<60 or >400." Other diagnoses include infected wound of the right foot and as having a PICC line.

During an interview on 4/22/2005 at approximately 9:30AM, that on 4/16/2005 at approximately 5:30AM, R1 performed a glucose check in the presence of E2, and the reading was 41. R1 stated during the interview that E2 did not take care of him correctly. R1 stated during the interview, that he felt really bad and he knew that

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146069	A. BUILDING _____ B. WING _____	C 05/20/2005

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVER VIEW MANOR, LTD	**6131 PARK RIDGE ROAD LOVES PARK, IL 61111**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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) COMPLETION DATE
F9999	Continued From page 43	F9999		

he needed something with sugar. R1 said that he wheeled to the nurses' station, and E2 was not there. R1 further stated that he then wheeled a distance to the employees break room, and saw E2 smoking and giving report. R1 stated that E2 told R1 to go back to the nurses' station and wait until she was finished with report. R1 and E2 also stated during their interviews that E2 then gave R1 some sugar free orange drink at approximately 6:10AM - 6:15AM and then E2 went home. R1 stated that he knew that the drink was sugar free and would not help him. R1 stated he did not eat any breakfast, but did eat the noon meal. R1 further said that no one came down to his room and did anything concerning his low blood sugar. R1 stated that no other glucose testing was done until 4PM that evening.

E2 (Licensed Practical Nurse) stated on 4/22/2005 at approximately 1:13PM that she did not bring any orange juice or any other source of glucose to R1's room before he got up. E2 repeatedly stated that R1 was asymptomatic so she saw no reason for concern on 4/16/2005. E2 did not provide any diabetic care such as providing glucose sources to treating hypoglycemia, rechecking glucose levels a second time after they were low, or instructing the resident to stay in bed to prevent injury until glucose levels had risen and were stable. When R1 arrived at the break room, E2 stated that she instructed R1, while she gave report, to go to the nurses' station and she would get R1 some juice; however E2 then stated that she had no orange juice available on 4/16/2005. E2 and R1 both stated during their respective interviews, that E2 gave R1 a sugar free orange drink at approximately 6:10AM. E2 stated that after she gave report on 4/16/2005, and gave R1 the sugar

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146069	A. BUILDING _____ B. WING _____	C 05/20/2005

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVER VIEW MANOR, LTD	**6131 PARK RIDGE ROAD LOVES PARK, IL 61111**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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) COMPLETION DATE
F9999	Continued From page 44	F9999		

free drink, she went home.

Review of R1's nurses¿ notes and interview with E2 on 4/22/2005 at approximately 1:13PM, showed that R1's physician was not notified of the glucose test at 5:30AM on 4/16/2005. Review of R1's nurses notes and verification during an interview with E7 on 4/22/2005, showed that R1's physician was not notified of the blood glucose reading of 41 until 4/18/2005, two days later. Review of R1's MAR dated 3/2005 identifies R1's glucose level on 3/25/2005 at 6AM as 47.

E7 (Director of Nursing) stated on 4/22/2005 at approximately 2PM that the physician was not called and there is no documentation contained in R1's chart to indicate that R1's physician was ever called. E7 stated that the glucose reading of 47 was never reported. Review of R1's MAR dated 4/2005 shows that the glucose test ordered for 6AM 4/15/2005 was never performed. E7 further stated there is no documentation in R1's record to show the test was ever done.

During an interview on 5/3/2005 at approximately 1PM, E8 (Registered Nurse) stated that E2 should have followed the facility's policy and procedures concerning care of a diabetic resident having a low blood glucose level, that E2 should have provided a source of glucose on 4/16/2005 and that E2 should have repeated glucose testing as per policy and procedure, and that all the nurses were aware that the orange drink was a sugar free drink. E8 stated that all the nurses had requested that the facility acquire a sugar free drink for the diabetic residents. E8 further stated that the sugar free drink was not the correct drink to give to R1 when his glucose reading is below 60. E8 stated that E 2 should not have allowed R1 out of his bed until

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146069	A. BUILDING _____ B. WING _____	C 05/20/2005

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVER VIEW MANOR, LTD	**6131 PARK RIDGE ROAD LOVES PARK, IL 61111**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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) COMPLETION DATE
F9999	Continued From page 45	F9999		

his glucose had risen to a safe level and also said that R1 was in danger of falling out of his wheel chair. E8 stated during the interview that R1 is knowledgeable about his diabetes.

On 5/18/2005 at approximately 12:30PM, when questioned concerning the facility's diabetic's care policy and procedure, E2 was unable to state what she should do, according to the facility's policy and procedure, when a resident experiences hypoglycemia.

R1's MAR also identified an order to apply Bucks Traction nightly and a daily dressing change to the right foot.

During an interview on 4/22/2005 at approximately 9:30AM, R1 stated, that on two occasions E2 (Licensed Practical Nurse) wrapped the gauze dressing on his foot too tight.

During an interview on 4/22/2005, at approximately 2PM, E7 (Director of Nursing) stated, that R1 asked for the scissors to cut the dressing on his foot because it was too tight. E7 stated that she cut and loosened the dressing. On 4/22/2005 at approximately 9AM, R1 was observed to have two amputated toes.

R1 further stated during the interview, that on one occasion he reported to E8 (Registered Nurse) that his dressing was to tight.

E8 stated on 5/3/2005 during an interview at approximately 1PM, that she was asked by R1 to loosen the dressing on his foot because it was to tight. E8 further stated that she did re-wrap R1's dressing, and that R1 had no further complaints.

R1's current care plan dated 3/30/2005 and 4/15/2005 fails to identify the care needed for R1's

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146069	A. BUILDING _____ B. WING _____	C 05/20/2005

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVER VIEW MANOR, LTD	**6131 PARK RIDGE ROAD LOVES PARK, IL 61111**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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) COMPLETION DATE
F9999	Continued From page 46 PICC line, diabetic care, bucks traction and the infected right foot/treatment and dressings. The facility Care Plan documentation policy and procedure for residents with Diabetes Mellitus requires care plans contain the following documentation: · Identify specific problems related to diabetes mellitus. · List all risk factors that affect the care plan. · List all complications that require care or impede goal achievement. · List approaches to treat identified problems. · List approaches to monitor the residents' response to treatment. · List approaches for preventive measures. · List approaches to resident and care giver teaching. · List approaches for observation and reporting of complications. E1 (Administrator) stated on 5/11/2005 at approximately 3:50PM that R1's care plan did not address these areas. Example 2: R2, a non-diabetic resident, was given insulin twice between 4/19/05 and on 4/26/05. R2 was hospitalized for stabilization after both hypoglycemic reactions. R2's medication administration record (MAR) dated 4/2005 identifies R2 as having diagnosis of Right Breast Cancer, Atrial fibrillation/rapid rate, Hypertension, Insomnia, Tachycardia, Anxiety, Central Nervous System Hemorrhage, Urinary Tract Infection, and Congestive Heart Failure. R2's nurses notes dated 4/19/2005 at 7:40PM, contain documentation that R2 was found unresponsive, "blow" breathing with foam running	F9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146069	A. BUILDING _____ B. WING _____	C 05/20/2005

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVER VIEW MANOR, LTD	**6131 PARK RIDGE ROAD LOVES PARK, IL 61111**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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) COMPLETION DATE
F9999	Continued From page 47	F9999		

down the side of her mouth. R2's eyes were open. R2's husband, who was present at the time, stated that R2 was to be sent to the hospital

R2's hospital lab readings dated 4/19/2005 identify 250mg/dl of Glucose in the urine. Normal readings are negative. R2's hospital lab findings for blood glucose readings dated April 19 to 20, 2005 identify the following blood glucose readings: 10:07PM - 119mg/dl, 11:47PM - 44mg/dl, 12:40PM - 104mg/dl, 3:23AM - 47mg/dl, 3:56 AM - 39mg/dl, and 5:44AM - 47mg/dl; hospital normal readings are 70-99mg/dl.

Z4, R2's physician, documented in the hospital progress notes dated 4/20/2005 that R2 was admitted with a prolonged hypoglycemia. Z4 documented that R2 is not a diabetic, and that the hypoglycemia may have been medication induced. Z4 documented in the hospital progress notes dated 4/21/2005 that he suspects a medication error at the nursing home caused the hypoglycemic reaction. During an interview on 5/17/2005 at approximately 12:30PM, Z4 stated that tests were conducted on R2, and all the tests administered to R2 led Z4 to the conclusion that R2's hypoglycemic reaction, and was medication induced when R2 was at the facility.

R2's nurses notes dated 4/26/2005 contain documentation that at 6AM Z3 (agency Licensed Practical Nurse) entered R2's room with a blood glucose testing machine, an alcohol swab, and a syringe with insulin. Z3 asked R2 if she was R10 and R2 replied that she was. Z3 informed R2 that she needed to do a blood glucose test. The documentation goes on to state that Z3, after the test, administered insulin to R2. After the insulin injection was administered to R2, R2 asked Z3 what she was doing. Z3 again explained what she had just completed, and R2 informed Z3 that

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146069	A. BUILDING _____ B. WING _____	C 05/20/2005

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVER VIEW MANOR, LTD	**6131 PARK RIDGE ROAD LOVES PARK, IL 61111**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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) COMPLETION DATE
F9999	Continued From page 48	F9999		

she does not receive insulin, and that she had just returned from the hospital because of that. R 2 informed Z3 that she was R2. Z3 gave R2 orange juice, and notified Z4 and talked with R2's family.

R2's nurses' notes contain documentation that R2's blood glucose was not being monitored on 4/26/2005 after the wrongfully administered insulin. At 2PM, when an order was obtained to perform glucose testing every two hours the facility staff began to monitor R2's glucose level. R2's nurses' notes contain documentation on 4/27/2005 at 6AM, that R2's blood glucose test reading was 60. R2 became confused. At 6:15 AM R2 became diaphoretic with a glucose reading of 54 and sugar was given. At 6:30AM blood glucose test reading was 54 and two packs of sugar were placed on the tongue. The Ambulance was called.

The facility did not administer 15 grams of carbohydrate and wait 15min and retest. If the reading is still less than 70mg/dl, then repeat the administration of another 15grams of carbohydrate, and retest, etc. as needed according to their policy and procedure on Treatment of Hypoglycemia.

During an interview on 5/17/2005 at approximately 11:20AM, Z3 stated that she did work on 4/26/2005 and that she did wrongfully administer 48 Units of Lente insulin to R2 after looking at R10's MAR. Z3 stated that there were no pictures of R2 in the MAR. Z3 further stated that there are no residents' names on the individual resident's room doors, and that the residents do not wear name bracelets. Z3 did not monitor R2 blood glucose level after administering the insulin. Z3 documented in the nurses notes that R2, when asked, denied any

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146069	A. BUILDING _____ B. WING _____	C 05/20/2005

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVER VIEW MANOR, LTD	**6131 PARK RIDGE ROAD LOVES PARK, IL 61111**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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) COMPLETION DATE
F9999	Continued From page 49 signs or symptoms of hypoglycemia. Z3 stated that 4/26/2005 had been the first time she had been at the facility for approximately 5 years, and that she was not at all familiar with any of the residents. Z3 stated that she had not received any orientation to the facility. Z3 further stated that the only things that the departing nurse told her was that the room layout was confusing, and that Z3 must do a blood glucose test on R11 before administering insulin. Z3 stated if there had been some way to correctly identify the residents, a medication error would not have occurred. The facility MARs for 5/2005 were reviewed on 5/13/2005. There were no pictures on the 5/2005 MAR for R12, R13, R14, R15, R16 . There were no resident's room numbers written on 28 of the 33 pictures in the MAR. During an interview on 5/13/2005, E1 (Administrator) stated that the residents do not wear name bracelets, or any other means of identification. E1 also stated that the residents' names and room numbers are not on the individual resident's room doors or pictures. On 5/18/2005 at approximately 10AM, E1 stated that there is no orientation program/policy or procedure for the agency nurses or the newly hired nursing staff. E1 was asked for the policy on Medication Administration on 5/13/2005 and again on 5/18/2005 at approximately 10AM. E1 was unable to state or produce a policy and procedure concerning the administration of medication. R2's resident assessment, dated 9/13/2004, assessed R2 as needing assistance to move in bed, walk/locomotion, to perform personal hygiene, transfer, and to bathe; R2 has balancing	F9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146069	A. BUILDING _____ B. WING _____	C 05/20/2005

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVER VIEW MANOR, LTD	**6131 PARK RIDGE ROAD LOVES PARK, IL 61111**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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) COMPLETION DATE
F9999	Continued From page 50	F9999		

problems with limited range of motion and partial loss of voluntary movement in her hand, arm, leg and foot. A Hospital Physical Therapy (PT) assessment, dated 12/24/2004, identified areas of need for R2 as balance, bed mobility, neuro-muscular re-ed, plan of care, safety, transfers. R 2's Hospital PT identified problem areas of decreased muscle strength, decreased bed mobility, decreased transfer activities, unsteady balance, non-ambulatory. Facility care plan includes therapeutic exercise, therapeutic activities, and balance activities. R2's care plan dated 9/8/2004 identified R2 as having a restricted mobility problem due to limited ability to balance self while standing. R2's care plan dated 5/10/2005 identified at risk for skin tears. One of the facility's approaches is to encourage R2 to stand/ambulate independently using adaptive device. R2's care plan identified a problem of poor balance with a history of CVA with right side weakness. One approach is to have a program for balance. There are no specific approaches addressing the multiple incidents of skin tears and bruising dating back since 9/2004.

Review of R2's nurses' notes identifies injuries occurring on:

· 9/20/2004 R2 was left alone and sustained injuries,

· 10/9/2004 R2 was being assisted by two staff and fell, sustaining a skin tear.

· 3/23/2005 R2 fell of a scale with staff present,

· 5/1/2005 R2 sustained a skin tear while being turned and lost her balance sustaining a skin tear,

· 5/9/2005 R2 sustained a skin tear requiring 13 stitches while being transferred.

E11 (RN/MDS and Care plan Coordinator) stated on 5/18/2005, during an interview at

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146069	A. BUILDING _____ B. WING _____	C 05/20/2005

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVER VIEW MANOR, LTD	6131 PARK RIDGE ROAD LOVES PARK, IL 61111

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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) COMPLETION DATE
F9999	Continued From page 51	F9999		

approximately 1:30PM, that R2 was in a restorative program and refused physical therapy . E11 was asked for a copy of the balance program, and E11 indicated there was none, but presented a program on mobility.
R2's care plan does not address repeated falls, skin tears and bruising, or the 13 stitches R2 acquired on 5/9/2005 during a transfer to or from the toilet. R2's plan of care does not address interventions, monitoring or the supervising of R2 when doing the activities that caused R2 to acquire injuries.

Example 3:
Surveyor reviewed the records of other residents whom the facility identified as diabetics. Inconsistencies were noted as follows:
R21 has a physician's order dated 1/26/05 to complete blood glucose testing on alternating shifts. Glucose testing was not done on 5/3/2005

R20 has a physician's order dated 2/12/05 to notify the physician if the blood glucose is below 60 or above 400. The glucose test done on 4/5/05 had a reading of 43. The physician was not notified.

R19 has an order dated 12/3/04 to administer sliding scale insulin of 6 units for a reading of 251 -300. The glucose test done on 5/14/05 showed a reading of 264. No insulin was administered as ordered.

R18 has an order dated 3/22/05 to administer Lantus Insulin 6 Units subQ every bedtime. The 5/2005 MAR identifies that on 5/15/05, R18 did not receive his bedtime insulin.

R15 has an order dated 4/2005 to administer blood glucose testing twice a day. The MAR sheet dated 4/2005 showed that the glucose test

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146069	A. BUILDING _____ B. WING _____	C 05/20/2005

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVER VIEW MANOR, LTD	**6131 PARK RIDGE ROAD LOVES PARK, IL 61111**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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) COMPLETION DATE
F9999	Continued From page 52 was not done on 4/21/04 at 6AM. R10 has an order on the 3/05 MAR to call the physician if the blood glucose reading is below 60 or above 250. The MAR dated 3/05 identifies the glucose test reading as 255. The 5/05 MAR identifies the glucose test reading as 265. The physician was not notified. R11 has an order on dated 1/14/05 to administer glucose testing before meals and at bed time; notify the physician if the results are below 60 or above 400. On 4/1/05 and 4/19/05 the 11AM glucose tests were not done. On 4/23/05 the 5AM glucose test was not done. On 4/26/05 at 5AM the glucose test reading was 36; the physician was not called. On 4/12/05 and 4/26/05 the 8PM glucose tests were not done.	F9999		