STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145736	A. BUILDING ______ B. WING ______	C 12/01/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALDEN TOWN MANOR REHAB & HCC	**6120 WEST OGDEN** **CICERO, IL 60804**

(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) COMPLETION DATE
F 333	Continued From page 2 incident report dated November 30, 2011 documents this error and disciplinary action was taken against the nurse. On December 1, 2011 at 3:30pm, E2 stated the medication was dispensed by pharmacy at 50mg tabs and R1 was given 5 tablets to equal the dose. Review of the nursing progress notes and medication incident report dated November 30, 2011, documents that R1 had complaints of pain upon urination.	F 333		
F9999	FINAL OBSERVATIONS LICENSURE VIOLATIONS 300.1210b) 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. Restorative measures shall include, at a minimum, the following procedures: Section 300.3240 Abuse and Neglect a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident.	F9999		

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F9999	Continued From page 3	F9999		

These requirements were not met as evidenced by:

Based on record review and interview the facility failed to ensure that 2 residents (R4, R1) received the right medication and right dose freeing them from significant medication errors.

Findings Include:

1. R4 was admitted to the facility on August 29, 2011 for End Stage Renal Disease, Diabetes and Hypertension, with a plan for long term skilled nursing care.
The MAR (Medication Administration Record) for the month of November list an order for Novolog Insulin to be given for sliding scale purposes if R4 blood glucose is 150 or greater. R4's last recorded blood glucose results at 6am was documented as 99 and at 5:30pm 104.
Review of the facility's medication error incident reports reveals that on September 19, 2011 at 5:00pm R4 received a dose of Insulin, instead of the Heparin 5,000 units that was ordered for 6:00pm. According to E5's, (Licensed Practical Nurse) statement of events, E5 filled a 1 ml (milliliter) syringe with what was assumed to be Heparin, but was Novolg insulin, then injected 100 units subcutaneous into the R4. Review of the nursing progress notes dated September 19, 2011 at 6:30pm denotes that R4 became cold, clammy, lethargic with a blood glucose level of 52 after the administration of what was presumed to be heparin. The physician was then notified, glucagon was given to help increase the blood

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F9999	Continued From page 4	F9999		

sugar, 911 was called and R4 was sent by ambulance to the hospital.

On December 1, 2011 at 2:15pm E2, Director of Nursing stated that the incident report and events listed were correct and verified her signature as the person who conducted the investigation and completed the medication error incident report. Review of E5, employee file denotes a disciplinary action report referencing the above incident violation, requiring E5 to be further monitored for 2 weeks when administering medication.

Review of the hospital medical records documents that on September 19, 2011, R4 was treated in the emergency room, them admitted to the ICU (Intensive Care Unit) with a diagnosed of Hypoglycemia. Hospital stayed equaled 4 days, then R4 was transferred to another long term care facility per family request.

2. R1 was admitted into the the facility on October 27, 2011 and was being treated for a Urinary Tract Infection. According to the POS (Physician Order Sheet) for the month of November, R1 was to received Macrobid 250mg (milligrams) twice a day for 8 days, starting November 25, 2011. According to the MAR (Medication Administration Record), R1 missed 3 doses of the medication on November 25-26. Review of the medication error incident report dated November 30, 2011 documents this error and disciplinary action was taken against the nurse. On December 1, 2011 at 3:30pm, E2 stated the medication was dispensed by pharmacy at 50mg tabs and R1 was given 5 tablets to equal the dose. Review of the nursing progress notes and medication incident report

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F9999	Continued From page 5 dated November 30, 2011, documents that R1 had complaints of pain upon urination. (B)	F9999		