Illinois Department of Public Health

STATEMENT OF DEFICIENCIES		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIP	LE CONSTRUCTION	(X3) DATE	SURVEY							
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	A. BUILDING	:	COMPLETED								

		IL6014666	B. WING		12/10/2014								
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY.	STATE, ZIP CODE									
850 DUNHAM RD													
ROSEWOOD CARE CENTER OF ST CHARLES ST CHARLES, IL 60174													
/V4\ 1D	SLIMMADV STA	TEMENT OF DEFICIENCIES	T			1							
(X4) ID PREFIX TAG	(EACH DEFICIENCY	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	(X5) COMPLETE DATE								
60000	Final Observations		00000										
59999	Final Observations		S9999										
	Otalamant of the	N.C. 1. 4											
	Statement of Licen												
		dministration of Medication				-							
	d) If, for any reason	, a licensed prescriber's											
A A A 11		annot be followed, the licensed											
		notified as soon as is											
	reasonable, depending upon the situation, and a notation made in the resident's record. This REQUIREMENT is not met as evidenced by:												
						-							
				P. III.									
	Based on interview	and record review the facility											
	failed to notify the re	esident's physician that											
		sident was not available for ten											
	administration times					The second secon							
		7 residents (R104) observed											
	during medication administration.												
	The Findings includ												
	According to the De	ecember 2014 Physician Order											
		agnoses including Congestive											
	Heart Failure, Atrial												
	cardioversion. The orders included Amlodipine												
	Besylate 5 milligrams to be given twice daily at												
	8:00am and 4:00pm but hold if systolic blood pressure is less than 110 or heart rate less than 60 beats per minute. During medication pass administration on												
	12/07/2014 at 3:55n	om E3 (Registered Nurse)											
The second secon	stated that R104's n	nedication Amlodipine was not											
	available because the	he pharmacy needed											
		nedication. The Medication											
		ord (MAR) showed that											
		given during the following				İ							
		s: 12/02/2014 at 8:00am with a											
		18/70 and a heart rate of 97;				ł							
		om with a blood pressure of											
		rate of 97; 12/03/2014 at											
		pressure of 156/94 and a											
		04/2014 at 8:00am with a											
	hlood proceure of 14	12/88 and a boost rate of 82:											
blood pressure of 142/88 and a heart rate of 82; 12/04/2014 at 4:00pm with a blood pressure of 136/72 and a heart rate of 101; 12/05/2014 at													
	130/12 and a neart I	ate of 101, 12/05/2014 at				1							

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(X6) DATE

TITLE

01/06/15

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING: B. WING NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 850 DUNHAM RD ST CHARLES, IL 60174	TED
IL6014666 B. WING	2014 (X5) COMPLETE
IL6014666 B. WING	(X5) COMPLETE
NAME OF PROVIDER OR SUPPLIER ROSEWOOD CARE CENTER OF ST CHARLES STREET ADDRESS, CITY, STATE, ZIP CODE 850 DUNHAM RD ST CHARLES, IL 60174	(X5) COMPLETE
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 850 DUNHAM RD ST CHARLES, IL 60174	(X5) COMPLETE
ROSEWOOD CARE CENTER OF ST CHARLES 850 DUNHAM RD ST CHARLES, IL 60174	COMPLETE
ST CHARLES, IL 60174	COMPLETE
ST CHARLES, IL 60174	COMPLETE
	COMPLETE
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION	COMPLETE
PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (FACH CORRECTIVE ACTION SHOULD BE	DATE
TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE	
DEFICIENCY)	
S9999 Continued From page 1 S9999	
8:00am with a blood pressure of 152/80 and a	
heart rate of 92; 12/05/2014 at 4:00pm with a	
blood pressure of 140/72 and a heart rate of 90;	
12/06/2014 at 8:00am with a blood pressure of	
146/84 and a heart rate of 92; 12/06/2014 at	
4:00pm with a blood pressure of 124/82 and a	
heart rate of 88; and 12/07/2014 at 4:00pm with a	
blood pressure of 142/82 and a heart rate of 66.	
R104's MAR nurse's medication notes only	
showed documentation that the Amlodipine was	
not available on 12/02/2014 at 4:00pm,	
12/04/2014, 12/05/2014 at 8:00am, and	
12/07/2014 at 4:00pm.	
On 12/08/2014 at 3:50pm E1 (Administrator) said	
that the facility was waiting for insurance approval	
for R104's Amlodipine. She said that R104's	
doctor and power of attorney was notified that the	
medication was not available and it would be charted in the nurse's notes.	
R104's nurses notes dated 12/08/2014 at 5:30pm showed that the doctor was made aware of the	
medication not being available and that the	
medication would be delivered on that day. This	
notification was made after the issue was brought	
to the facility's attention by the survey team.	
On 12/09/2014 at 11:50am, Z1 (Staff who enters	
Pharmacy Order) said that R104's medication	
order for Amlodipine was filled and sent to the	
pharmacy in the months of September, October,	
November, and December. Z1 said that the	
November 16, 2014 order was received by the	
facility on November 17, 2014. Z1 said that there	
weren't any issues with the insurance company or	
the medication would not have been sent out.	
On 12/09/2014 at 12:20pm, Z2 (Pharmacy	
Director) said that a refill request was made by	
the facility for R104's Amlodipine on 12/03/2014.	l
Z2 stated that the pharmacy was not made aware	
that the facility did not have enough Amlodipine	l
medication until 12/08/2014. Z2 said that R104's	l

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		IL6014666		B. WING		12/	10/2014	
	PROVIDER OR SUPPLIER	OF ST CHARLES	850 DUNH		STATE, ZIP CODE			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY I SC IDENTIFYING INFORMA	FULL	ID PREFIX TAG	PROVIDER'S PLAN C (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLETE DATE	
S9999	Amlodipine was dis 10/22/2014 and 11/there should have the medication remaining On 12/09/2014 at 1 stated that he was 12/08/2014 that R1 Amlodipine medication be would be notified was not available. The facilities Medic Documentation polithat an omission of note on the back of medication was not included "If the omittreatment is due to	spensed on 09/29/201/17/2014 and on 12/08/2014 and on 12/08/2019 at least 13 daysing. :13pm Z3 (Medical Dinotified in the evening 04 had not been receition. Z3's expectation dias soon as the medications/Treatments by dated 03/2010 inclored a medication should the MAR explaining of a medication a medication being the pharmacy or the	a/2014 of octor) g of iving his was that ication uded d have a why the o	S9999				

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