STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	14E238	A. BUILDING _____ B. WING _____	C 07/28/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ABBOTT HOUSE	**405 CENTRAL AVENUE HIGHLAND PARK, IL 60035**

(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 000	INITIAL COMMENTS Complaint Investigation #1513942/IL78818--No deficiency Complaint Investigation #1513972/IL78847--F333	F 000		
F 333 SS=D	483.25(m)(2) RESIDENTS FREE OF SIGNIFICANT MED ERRORS The facility must ensure that residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to administer medication as ordered by the physician. This applies to 1 of 3 residents (R1) reviewed for medications administration upon readmission from the hospital in the sample of 5. The findings include: R1's admission record shows she was admitted to the facility on June 2, 2015. Nurse's notes dated June 19, 2015 state that R1 was transferred to the hospital for evaluation and treatment. Nurse's notes dated July 6, 2015 at 8:00 PM show R1 was readmitted from the hospital. Hospital staff reported that R1 had several seizures while there due to non compliance with medications. R1 began taking her medication and got better. R1's physician order sheet dated 7/6/15 lists	F 333		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE 08/19/2015

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 333	Continued From page 1 epilepsy under diagnoses with two medications indicated for seizure disorder, Oxcarbazepine and Levetiracetam. R1's MAR (medication administration record) from July 6, 2015 through July 14, 2015 shows Oxcarbazepine 300 mg. is ordered three times a day at 8:00 AM , 4:00 PM, and 8:00 PM. The MAR shows none was given at 8:00 PM on July 6, 2015. Levetiracetam 500 mg. is ordered every 12 hours at 8:00 AM and at 8:00 PM. There was none given on July 6, 2015 at 8:00 PM, and the 8:00 AM dose on July 7 2015 was not given. There is NA (not available) written in the 8:00 AM block on July 7, 2015. On July 28, 2015 E1 at 11:00 AM (administrator) said that R1 was discharged too late from the hospital for the facility to have enough time to order medications before 8:00 PM on July 6, 2015.	F 333		