		ND HUMAN SERVICES MEDICAID SERVICES						/I APPROVED). 0938-0391
STATEMENT OF DEFICIENCIES (X1) PROVIDER AND PLAN OF CORRECTION IDENTIFICA		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING				(X3) DATE SURVEY COMPLETED	
		14G281	B. WING	/ING				04/12/2013
NAME OF PR	OVIDER OR SUPPLIER	·	STREET ADDRESS, CITY, STATE, ZIP CODE					
GROUP H	OME #2			224 BACHMAN LANE GODFREY, IL 62035				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG	ΞIX	PROVIDER'S PLAN OF CORI (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	HOULD B		(X5) COMPLETION DATE
W 000	INITIAL COMMENTS		w	00	ю			
	ANNUAL CERTIFIC	ATION SURVEY -						
	INSPECTION OF CA							
W 111	LICENSURE SURVE 483.410(c)(1) CLIEN	w	/ 11	1				
	The facility must dever recordkeeping syster health care, active tre and protection of the							
	This STANDARD is a Based on interview a failed to develop med medication errors for sample. (R2, R3, R4							
	Findings Include:							
	Policy" under the sec states, "1) If and whe error occurs, the nurs complete a medicatio Attached) 2) If a sta be reported immedia Nurses], ADON [Assi the nurse in charge of nurse receiving the re	Medication Error Report etion titled "Procedure" en a medication/treatment se discovering the error will on error report form. (See ff discovers the error, it will tely to the DON [Director of distant Director of Nurses], or of the area at that time. The eport will ensure that ort form is completed."						
	(MAR) of 2/01/13 thro	n Administration Record ough 2/28/13, is a 47 year R of 2/13 states that she is						

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

DEPARTMENT OF HEALTH AND HUMAN SERVICES.

TITLE

(X6) DATE

PRINTED: 05/02/2013

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.

FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING 14G281 B. WING 04/12/2013 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 224 BACHMAN LANE **GROUP HOME #2** GODFREY, IL 62035 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X4) ID ID (X5) COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) W 111 Continued From page 1 W 111 to receive Vitamin D2 1 capsule every week at 7:00am. on Friday. On the back of the MAR of 2/13 is hand written "2-2-13 1130 Vitamin D2 PO [by mouth] Not Available." E1 (Registered Nurse, Nurse Trainer) was interviewed on 4/11/13 at 3:30pm. When asked if a medication error report was filled out for this omission, E1 stated she would have to check. 2) R3, per MAR of 3/01/13 through 3/31/13, is a 46 year old female. R2's MAR of 3/13 states that she is to receive Vitamin D3 every week on Wednesday at 7:00am. On the back of the MAR of 3/13 is hand written "3-6-13 7 am Vitamin D-3...Unavailable Nurse Notified." That date is circled on the front of the MAR. A Hand written MAR for 2/13 states R3 is to receive Vitamin D3 one time weekly. On the back of the hand written MAR for 2/13 is hand written "2-27 7:06 Vitamin D3...Out." E1 during the interview of 4/11/13 at 3:30pm. stated she would check on these also. On 4/12/13 at 10:20am, E1 stated that she wasn't able to find any medication error reports for any of these incidents. E1 was asked the if there is no evidence that medication reports were filled out for these omissions. E1 stated no. 3) R4, per MAR of 1/13, is a 47 year old male. R4's MAR for 1/13 states that R4 is to receive Quetiapine Fumarate 100mg 1 tablet twice a day for Aggression. Hand written on the back of the MAR for 1/13 is 1/10/13 Quetiapine Fumarate 100mg Not Available.

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DEPART CENTER	PRINTED: 05/02/2013 FORM APPROVED OMB NO. 0938-0391									
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED				
		14G281	B. WING			04/12/2013				
NAME OF PROVIDER OR SUPPLIER					TREET ADDRESS, CITY, STATE, ZIP CODE					
GROUP HOME #2					224 BACHMAN LANE GODFREY, IL 62035					
(X4) ID PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	PREF	FIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE			
W 111	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 2 E1 was asked on 4/12/13 at 10:20am., if she had located any medication error reports for that omission. Also, hand written on the back of the MAR for 1/13 is 1/25/13 Lamictal Not Available.		W 111							

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Event ID: GG9T11

Facility ID: IL6012900

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