STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145867	A. BUILDING _____ B. WING _____	**03/13/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
FAIRMONT CARE	**5061 NORTH PULASKI ROAD CHICAGO, IL 60630**

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0684 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Provide appropriate treatment and care according to orders, resident's preferences and goals.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on Record Review and Interview the Facility failed to provide Medication for Anticoagulation, Antidiabetic and Kidney Transplant to 1 of 1 resident (R10) reviewed in the sample of 3 (R10, R11 and R12). These failures have the potential to affect 1 residents (R10) medical health status. Findings Include: During the investigation R10 was not in the facility. R10's Admission, Discharge, Transfer (ADT) Activity Detail Report reads that R10 was discharge to the hospital on [DATE]. R10's Medical Record reads that R10 has the following Medical Diagnosis: [REDACTED]. R10's Medical Record reads that R10 has the following medications listed below. These medications were included in his list of medication during readmitted d 1/9/20. R10's Admission, Discharge, Transfer (ADT) Activity Detail Report reads that R10 was discharged to the hospital on [DATE] and was readmitted back to the facility on [DATE]. During readmission of R10, those medications listed below were not included in the medication list until it was reordered on [DATE]. The following medications are: [MEDICATION NAME] 50 MG tablet one daily for Kidney Transplant. [MED] 90 MG tablet two times per day for anticoagulation of the blood. [MEDICATION NAME] U - 100 [MED] 100 unit per ML subcutaneous injection 5 units at bedtime for Diabetes Mellitus. R10 has a [DIAGNOSES REDACTED]. R10's Treatment Administration Record reads that [MEDICATION NAME] 50 [MED] 90 MG and [MEDICATION NAME] U - 100 [MED] 100 per ML medications was not signed as given from 1/25/20 to 2/26/20. R10's Progress Notes written by V12 (Attending Physician) dated 2/22/20 reads: R10 has Coronary Arterial Disease status [REDACTED]. Last stent surgical procedure was 7/19. Continue [MED]. Treatment Administration Record shows that R10 was not receiving [MED] since last readmitted d 1/25/20. On 3/12/20 at 9:50 AM. V3 (Director of Nursing) stated that the admitting nurse just followed discharge instructions of medication from the hospital packet when R10 was admitted . V3 does not know why the hospital, when they received the medication list, those three medications ([MEDICATION NAME], [MED] and [MEDICATION NAME]) were not included. V3 stated that the V12 (Attending Physician) was notified of the medications on the list. V3 stated when R10 went to V10 (Cardiologist) for an appointment that V10 informed R10 and V13 (R10's Daughter) that those three medications are not on the medication list. Afterwards V10 informed V12 that those three medications be reinstated. V3 stated R10 has medical [DIAGNOSES REDACTED]. On 3/12/20 at 11:44 AM. V14 (Medical Assistant for V10 - Cardiologist) stated that R10 went to see V10 on 2/26/20. V14 stated that based upon V10's notes the list of medications does not have anticoagulant for R10. And that R10 has [DIAGNOSES REDACTED]. V14 further stated that according to V10's notes R10 was supposed to get [MED] medication for anticoagulation due to history of stent replacement. On 3/13/20 at 11:23 AM. V12 (Attending Physician) stated, I did not discontinued those [MED], [MEDICATION NAME] and [MEDICATION NAME] Medications. I am sure there a miscommunication between the Hospital Nurse and the Receiving Nurse during readmission because those medications did not reflect on R10's Medication List. V12 stated that during readmission on 1/25/20, Admitting Nurse calls to verify discharge Medication List from the hospital. He just replied, continue all discharge medication from the hospital until I see R10. V12 stated, it is just a routine during admission or readmission. V12 stated, during January and February this year I only saw R10 on 2/22/20. I agree with V10 (Cardiologist), R10 should continue taking anticoagulant ([MED]). Facility Policy on Reconciliation of Medications on admitted d 2001 reads: The purpose of this procedure is to ensure medication safety by accurately accounting for the resident's medications, route and dosage upon admission or readmission to the facility. Medication reconciliation is the process of comparing medications by creating an accurate list of both prescription and over the counter medications that includes the drug name, dosage, frequency, route, and indication for use for the purpose of preventing unintended changes or omissions at transition points in care. Medication reconciliation helps to ensure that medications, routes and dosages have been accurately communicated to the Attending Physician and care team.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE