STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145878	A. BUILDING _____ B. WING _____	**08/25/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
ST PATRICK'S RESIDENCE	**1400 BROOKDALE ROAD NAPERVILLE, IL 60563**

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 observation, record review and interview the facility failed to follow physician's orders; the facility also failed to schedule follow up visits for residents diagnosed with [REDACTED]. Findings include: 1). The Face Sheet documents R1 is [AGE] years old and has [DIAGNOSES REDACTED]. The eye exam dated 9/17/19 by V8 (Optometrist) reads: hemorrhages left eye, refer to retina clinic, start [MEDICATION NAME] and [MEDICATION NAME]. The orders dated 9/17/19 by V8 reads: [MEDICATION NAME] 1% (ophthalmic solution), one drop to both eyes twice daily for [MEDICAL CONDITION]; [MEDICATION NAME] 0.2% (Ophthalmic solution), one drop to left eye three times a day for [MEDICAL CONDITION], refer to retina specialist. The Physician's Order Sheet (POS) and Medication Administration Record (MAR) for R1 was reviewed for Sep, Oct, Nov and [DATE]. The POS and MARs show the [MEDICATION NAME] was neither ordered nor administered. The [MEDICATION NAME] was not ordered until 12/17/19. The progress notes by V9 (Ophthalmologist/Retina Specialist) dated 9/23/19 shows R1 has inferior hemiretinal vein occlusion, history of [MEDICAL CONDITION]. Needs [MEDICAL CONDITION] specialist's opinion. Refer to [MEDICAL CONDITION] Specialist/Ophthalmologist (V7). The History and Physical (H&P) by V7 dated 12/17/2020 reads: Diagnosis: [REDACTED]. Instructions return in about 6 weeks (1/28/2020). The next visit to the Ophthalmology clinic was not until 2/14/2020 and with V9. The H&P by V9 reads: (2/14/20) return in about 6 months for Retina check with V9, and V7 within one month. On 8/24/2020, R1's medical record showed no follow up appointments with V7. On 8/24/2020 at 9:20 AM, R1 was in her room sitting in the chair. R1 was unable to visualize objects with her left eye when asked. R1 was able to visualize objects with her right eye. On 8/25/2020 at 11:14 AM, V7 ([MEDICAL CONDITION] specialist) stated she has not seen R1 since 12/17/19. V7 stated she ordered [MEDICATION NAME]. V7 stated there was no indication that R1 had been on [MEDICATION NAME] or [MEDICATION NAME]. V7 stated she asked for R1 to return to the clinic in one month, and that V9 gave another referral on 2/14/20 for R1 to see V7 in a month. V7 stated neither of us have seen her since. We should've seen her by now. V7 also stated R1s left eye has been bad for a long time and the goal is to save the right eye so R1 can have good quality of life. During this investigation on 8/24/2020, the facility called and scheduled R1's 6 month visit with V9 (Retina Specialist). However, there was no scheduled appointment with V7 ([MEDICAL CONDITION] Specialist). Review of R1's care plans showed no plan of care for vision/[MEDICAL CONDITION]. 2). The Face Sheet documents R3 is [AGE] years old and has [DIAGNOSES REDACTED]. The eye exam for R3 dated 2/18/2020 documents: atrophy right eye, recurrent erosion right eye. Order: Cequa eye drops twice a day for both eyes (for dry eyes). Follow up 2 months. On 8/24/2020 at 9:45 AM, R3 was in bed having breakfast. R3's left eye remained closed. Both eyes had yellow crusting. The medical record contained no follow up appointment as ordered. On 8/25/2020 at 2:30 PM, V2 (Director of Nursing) stated there has been no follow up appointment. V2 stated she can call R3's family to ask if they would like to schedule an appointment. 3). The Face Sheet documents R2 is [AGE] years old and has [DIAGNOSES REDACTED]. The optometry visit dated 8/20/19 notes that R2 has intra ocular pressure and is to have a follow up visit in 4 months. On 8/24/2020 there was no documented follow up visit in R2's medical record. The facility was asked to provide any follow up visits to no avail. On 8/25/2020, V2 provided the policy for physician's orders which reads: Telephone Orders Policy Statement- Verbal telephone orders may be accepted by each resident's attending physician Policy interpretation and implementation- 1). Orders must be reduced to writing by the person receiving the order and recorded in the resident's medical record. 2). The entry must contain the instructions from the physician, date, time, and the signature and title of the person transcribing the information. On 8/25/2020 at 3:17 PM, V2 stated the policy pertains to both written and verbal orders. V2 stated the policy is to document the order on the MAR and POS, and to ensure the order is carried out.

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

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.