

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  145659	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  03/24/2025
NAME OF PROVIDER OR SUPPLIER  Waterford Care Center, The		STREET ADDRESS, CITY, STATE, ZIP CODE  7445 North Sheridan Road Chicago, IL 60626	

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)
<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure services provided by the nursing facility meet professional standards of quality.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45000</b></p> <p>Based on observation, interview, and record review, the facility failed to provide care according to professional standards and properly label medication that had been open for resident use. These failures affect one (R1) resident out of three residents reviewed for medications.</p> <p>Findings Include:</p> <p>R1's physician order sheet/POS documents the following orders: Baclofen Tablet 10 MG- Give 1 tablet by mouth one time a day for musculoskeletal therapy agents.</p> <p>On [DATE] at 9:54 AM, V3 (Registered Nurse/RN) stated he has begun his medication administration pass already and is about to prepare R1's medications to administer. A medication bingo card was labeled Baclofen 5 mg, with a residents' name torn off of the label. R1's name was handwritten in black marker on the Baclofen medication bingo card.</p> <p>On [DATE] at 10:04 AM, V3 stated there was an issue with R1's Baclofen medication. V3 stated he was the nurse assigned to care for R1 on [DATE], and noticed R1's Baclofen medication was not available in the facility, and for some reason got lost. V3 stated he then called the pharmacy, and the pharmacy informed him R1's Baclofen medication was dispersed on [DATE], and was not due to be refilled until [DATE]. V3 stated later, the DON/Director of Nursing (identified as V2) brought a substitute bingo card with Baclofen medication inside to administer to R1 until R1's Baclofen medication can be refilled on [DATE].</p> <p>On [DATE] at 10:41 AM, R1 stated the facility informed her her Baclofen medication was not available in the facility. R1 stated she receives a 10 mg tablet of Baclofen, but the facility only had 5 mg tablets.</p> <p>On [DATE] at 3:41 PM, V11 (General Manager of Pharmacy) stated a 30-day supply of R1's Baclofen 10mg medication was dispensed to the facility on [DATE] at 2:40 PM, and signed by a facility staff member. V11 stated R1's Baclofen 10mg medication cannot be refilled at this time because it is too soon to be refilled. V11 stated since a 30-day supply was dispensed, R1's Baclofen 10mg medication should not have run out and should still be available in the facility.</p> <p>(continued on next page)</p>

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.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On [DATE] at 4:33 PM, V2 (DON) stated she was just made aware today R1's Baclofen 10mg medication was not available in the facility. V2 stated she is now made aware the nurses tried to reorder R1s' Baclofen medication, but it was too soon to be refilled. V2 stated she also just found out the nurses found a medication bingo card consisting of Baclofen 5mg and felt the need to administer this medication to R1 because they did not want R1 to miss a dose of medication. V2 stated she is aware the Baclofen 5mg bingo card has a residents' name torn off the label and R1's' name handwritten on it. V2 stated this is not a professional standard of practice, and nurses are not supposed to borrow medications from one resident and administer it to another resident. V2 stated this should never happen because residents could potentially be given the wrong medication or given expired medication. V2 stated she never supplied the nurses with the Baclofen 5mg medication bingo card to administer to R1. V2 stated she collects a lot of discontinued medication bingo cards and keeps them in her office until the pharmacy arrives to pick them up.</p> <p>Facility policy, dated ,d+[DATE], titled Storage and Labeling of Medications, documents, 4. Drug containers that have missing, incomplete, improper, or incorrect labels are returned to the pharmacy for proper labeling before storing.</p> <p>Facility policy, dated ,d+[DATE], titled Administering Medications, documents, 26. Medications ordered for a particular resident may not be administered to another resident</p>		

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<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that residents are free from significant medication errors.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 45000</p> <p>Based on interview and record review, the facility failed to ensure medications were administered as ordered by the residents' physician for one (R1) resident out of three residents reviewed.</p> <p>Findings Include:</p> <p>R1's physician order sheet/POS documents the following order: Ambien Oral Tablet 5 MG (Zolpidem Tartrate) *Controlled Drug*- Give 1 tablet by mouth at bedtime for Sleeplessness.</p> <p>On 03/23/2025 at 10:41 AM, R1 stated she did not receive her Ambien medication for 2 days after returning to the facility from completing her knee surgery at the hospital. R1 stated V2 (Director of Nursing/DON) told her that her Ambien medication was not available, and V2 was in the process of trying to get it.</p> <p>On 03/23/2025 at 3:33 PM, V7 (Registered Nurse/RN) stated when R1 came back from the hospital, R1 was prescribed Ambien, but it was not available. V7 stated she then called the pharmacy and made the DON aware. V7 stated she did not administer R1's Ambien to R1 on 03/05/2025, because it was not available. V7 stated if there is not a check mark documented on R1s' medication administration record/MAR, then it means the medication was not given.</p> <p>On 03/23/2025 at 3:41 PM, V11 (General Manager of Pharmacy) stated a 30-day supply of R1's Ambien 5mg medication was dispensed to the facility on [DATE] at 2:45 AM, and signed by a facility staff member. V11 stated R1's Ambien 5mg medications should have lasted until 03/20/2025. V11 stated the pharmacy received a refill request for R1's Ambien 5mg medication on 03/14/2025. V11 stated R1's Ambien 5mg medication was dispensed to the facility on [DATE] and signed by V10 (RN). V11 stated based on his records, R1 had a sufficient supply of Ambien 5mg medications, and there should not have been any lapses in R1 receiving her Ambien 5mg medication.</p> <p>On 03/23/2025 at 4:11 PM, V8 (RN) stated he did not administer R1's Ambien 5mg on 03/06/2025 because he could not find the medication in the facility. V8 stated if there is not a check mark documented on R1's medication administration record/MAR, then it means the medication was not given.</p> <p>On 03/23/2025 at 4:33 PM, V2 (DON) stated R1 went out for surgery on 02/24/2025, and was readmitted back to the facility on [DATE]. V2 stated she was not sure if all R1's medications were pulled from the medication carts and placed in a bag for pharmacy to pick up. V2 stated she spoke with R1 about her Ambien medication and checked herself, and did not see R1's Ambien medication in the facility medication cart to administer to R1. V2 stated she is not sure if Ambien medication is kept in the facility emergency box, and did not check to see if it was located inside the emergency box. V2 stated it is important to administer all medications to residents as prescribed by their physician.</p> <p>Record review documents R1 was hospitalized from 02/24/2025 to 03/04/2025.</p> <p>Nursing progress note, dated 03/05/2025, written by V7 (RN) at 9:58 PM, documents, Post Admission Charting: (R1) in a stable condition with no distress noted. Ambien tablet not supplied by pharmacy. Follow up call made to pharmacy and the DON made aware of the update.</p> <p>(continued on next page)</p>		

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<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>R1s' medication administration record/MAR documents R1s' Ambien medication was not administered on 03/05/2025 and 03/06/2025.</p> <p>Facility policy, dated 04/2024, titled Administering Medications, documents, 4. Medications are administered in accordance with prescriber orders, including any required time frame.</p>		