STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146118	A. Building B. Wing	02/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Prairieview at the Garlands	6000 Garlands Lane Barrington, IL 60010

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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. Based on observation, interview, and record review the facility failed to administer insulin according to manufacturer's instructions. This applies to 1 of 2 residents reviewed for insulin administration in the sample of 20. The findings include: R4's admission Record (Face Sheet) showed a current/recent admission date of 10/17/24. R4's face sheet showed a diagnosis of Diabetes Type II. R4's Order Summary Report as of 2/19/25 showed an order for 7 units of rapid-acting insulin (a medication to control blood sugar in diabetic patients) to be given at mealtime, if the resident eats his meal. The order showed the insulin was to be dispensed via a prefilled insulin pen. On 2/18/25 at 11:59 AM, V3 Registered Nurse (RN) began preparation of R4's insulin pen. V3 removed the pen's cap, attached a needle, dialed in 2 units, held the pen horizontally, and depressed the plunger. The needle cap remained in place and the tip of the needle was not visible through the opaque cap (a drop of insulin was not visible at the tip of the needle). V3 then dialed in 7 units of insulin, entered R4's room, wiped is abdomen with alcohol, removed the needle cap, then injected the insulin. V3 held the insulin plunger for less than 2 seconds, removed her thumb from the plunger, held the needle in his skin for less than 4 seconds, then removed the needle from his abdomen. The rapid acting insulin manufacturer's instructions (revision 2/2023) showed, after the needle is attached, small amounts of air may collect in the pen and to ensure proper dosing, Turn the dose selector to select 2 units. Hold the pen with the needle pointing up. Tap the top of the pen gently a few times to let any air bubbles rise to the top. Hold the pen with the needle pointing up. Press and hold in the dose button until the dose counter shows '0' .A drop of insulin should be seen at the needle tip. If you do not see a drop of insulin repeat steps . The instructions showed, following the priming of the pen, the desired insulin dose should be dialed in and the needle injected into the skin. The instructions continued, once the needle is injected the dose button should be pressed and when the insulin dial reads zero, the dose button should continue to be pressed and the needle left in the skin for a slow 6 count. The manufacturer instructions stated if the 6 count is not done with the dose button pressed, the full dose of insulin may not be administered. On 2/19/25 at 9:33 AM, V2 Director of Nursing stated, nursing staff should be following manufacturer's instructions. V2 said the purpose of priming the insulin pen is to ensure there are no air bubbles and the resident receives their full dose of insulin. V2 said the purpose of keeping the dose button pressed is to ensure the resident receives their full dose of insulin.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146118	A. Building B. Wing	02/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Prairieview at the Garlands	6000 Garlands Lane Barrington, IL 60010

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observation, interview, and record review the facility failed to have a properly functioning lock for the drawer containing the residents' emergency supply of controlled substances. This failure has the potential to affect all residents in the facility. The findings include: On 2/18/25 at 10:45 AM, during medication room inspection, the drawer containing the emergency supply of controlled substances was opened without a key. The lock was not functioning as intended. On 2/18/25 at 10:45 AM, V3 Registered Nurse stated, I have not checked or accessed this drawer in a long time. The document Ekit Contents showed the drawer contained, but not limited to, fentanyl patches, morphine, and oxycontin (all Schedule II narcotic pain medications.) On 2/19/25 at 9:33 AM, V2 Director of Nursing stated controlled substance have to be double locked. V2 said the controlled substance boxes, within the locked drawer, have a keyed lock but they are not affixed to the cabinet. V2 said controlled substances are double locked because they are more likely to be diverted compared to other medications. V2 said the emergency supply of narcotics are available for all residents to be used. V2 said if a provider order a controlled substance for a resident, the emergency supply would be used until pharmacy could deliver the regular supply. The facility's policy Controlled Substances (Revision 12/6/22) showed The facility complies with all laws, regulations, and other requirements related to handling, storage, disposal, and documentation of controlled medications . The facility's policy does not show controlled substances must be separately locked from non-controlled medications in a permanently affixed container.