STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145660	A. BUILDING _____ B. WING _____	07/24/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
WESTCHESTER HEALTH & REHABILITATION	**2901 SOUTH WOLF ROAD WESTCHESTER, IL 60154**

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 0658 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Ensure services provided by the nursing facility meet professional standards of quality.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to document administration of medication as ordered for four (R1, R2, R3 and R4) of four residents reviewed for documentation of medication administration. Findings include: R1 is an [AGE] year old female admitted originally on 08-22-2018 with most recent readmission on 04-01-2020 with medical [DIAGNOSES REDACTED]. R1's Medication Administration Record [REDACTED]. The classification of the medications include anticoagulants, anti-[MEDICAL CONDITION], anti-hypertensives and for [MEDICAL CONDITION] among others. 7-21-2020 at 12:40PM V19 (Case Manager) said, R1's Medication Administration Records (MAR) has many undocumented medications, vital signs, and pain assessments. R2 is a [AGE] year old female, originally admitted on [DATE] with most recent readmission on 4-23-2020 with medical [DIAGNOSES REDACTED]. R2's Medication Administration Record [REDACTED]. The classification of the medications include: antihypertensive, antidiabetic and anti-end stage kidney disease among others. R3 is an [AGE] year old female alert and oriented to self only Originally admitted on [DATE] with medical [DIAGNOSES REDACTED]. R3's Medication Administration Record [REDACTED]. The classification of the medications include: anti-hypertensive, anti-[MEDICAL CONDITION], anticoagulant and anti-[MEDICAL CONDITION] among others. R4 is a [AGE] year old female originally admitted on [DATE] with medical [DIAGNOSES REDACTED]. R4's Medication Administration Record [REDACTED]. The classification of the medications include: anti-[MEDICAL CONDITION], anti-hypertensive, anti-[MEDICAL CONDITION], anti-pain among others. 7-22-2020 at 10:15 am V5 (Registered Nurse/ Unit Manager) said I am not auditing the medication administration currently. I do not know who is not medicated. If the medication was not signed out it was not given. 7-23-2020 at 7:15 am V3 (Registered Nurse) stated if the MAR indicated [REDACTED]. If you did not document it, it was not done. 7-22-2020 at 3:30pm V2 (Director of Nursing) stated, my expectation is that the charged nurse is to document. If I see any blank spots in the Medication Administration Record, [REDACTED]. I was not aware that R1, R2, R3, and R4 had so many undocumented medications. 7-23-2020 at 10:35am V16 (Medical Doctor/ Medical Director) said, my expectation is that the nursing staff will give the medications as ordered and if they do not have it or is not given I need to know about. I was never informed that R1 and R4 or any other residents were not receiving the medications as ordered. Policy titled, Documentation (dated 2-2017) reads: Healthcare personnel will complete documentation using acceptable principles of documentation. When a Medication or treatment is administered, the nurse initials the appropriate box on the Medication Administration Record [REDACTED].
F 0755 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to administer pain medication for one (R4) of four residents reviewed for administration of medication. Findings include: R4 is a [AGE] year old female originally admitted on [DATE] with medical [DIAGNOSES REDACTED]. R4 is alert and oriented and documented to be cognitively intact (BIMS score of 15 as of 6-9-2020). Physician order [REDACTED]. 7-22-2020 at 11:30 a.m. Nurse V13 (Licensed Practical Nurse) said R4 is due for the [MEDICATION NAME] 5mg, but the medication is not here. The prescription was just faxed to the pharmacy that the doctor signed today. The [MEDICATION NAME] is due every 6 hours. 7-22-2020 at 2:00pm R4 said I am in a lot of pain to my left leg because the nurses have not given me the medications for the past several days. I got up at 3:00am in the morning because I could not tolerate the pain. When I am in pain I do not want to do anything. R4's Medication Administration Record [REDACTED]. V17 (Physiatrist/ Medical Doctor) Progress note dated 7-6-2020 documents (under assessment and plan): pain management: R4's pain will be managed. R4 is currently on [MEDICATION NAME] 5mg four times a day. 7-22-2020 at 3:30pm V2 (Director of Nursing) stated she was not aware that R4 is missing the pain medication. 7-23-2020 at 11:35 V16 (Medical Director/ Primary Physician) said,, My expectation is that the nursing staff will give the medications as ordered and if they do not have it or is not given I need to know about, I was never informed that R4 was not receiving the medications as ordered. Oral Drug Administration Policy (dated 8-16-2019) reads: Notify the practitioner about any drug that the patient refuses or that you withhold.

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.