STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145607	A. BUILDING _____ B. WING _____	03/05/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
MANORCARE OF PALOS HEIGHTS EAST	7850 WEST COLLEGE DRIVE PALOS HEIGHTS, IL 60463

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 0580 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based upon interview and record review the facility failed to notify the physician that medication was not administered as ordered for two of four residents (R1, R3) in the sample. Findings include; The (3/2010) medication administration policy & procedure includes; Suggested Documentation: unusual observations and subsequent interventions including communications with physician. 1.) On 2/27/20 at 3:50pm, R3 stated About a week ago they were a little bit slow on getting the medication for this infection I had. R3's (2/11/20) POS (Physician order [REDACTED]. R3's (February 2020) MAR (Medication Administration Record) affirms Micafungin was not documented as administered at 6:00am on 2/15/20 and 2/18/20 as scheduled. R3's (2/18/20) progress notes state; Micafungin medication was unavailable. On 3/2/20 at 12:05pm, V2 (Director of Nursing) presented R3's (2/15/20 and 2/18/20) progress notes and affirmed that there is no documentation that the physician was notified regarding Micafungin availability and/or administration. 2.) R1's ([DATE]) POS include; [MEDICATION NAME] 7.5-325mg (2 tablets) every 6 hours PRN (as needed). R1's (2/11/20) progress notes state in part; writer noticed that patient was out of [MEDICATION NAME] pain medication. Writer was not able to administer medication as ordered. (There is no documentation of physician notification regarding [MEDICATION NAME] availability and/or administration). On 3/5/20 at 1:20pm, V10 (Physician) stated If there's a change in condition they need to contact us, me or the NP (Nurse Practitioner). Surveyor inquired if V10 was made aware of R1's [MEDICATION NAME] running out V10 responded I don't recall that.
F 0697 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide safe, appropriate pain management for a resident who requires such services.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based upon record review and interview the facility failed to conduct a pain evaluation every shift, failed to renew a schedule II prescription (prior to running out of medication), failed to administer prescribed pain medication and failed to timely notify the physician of change in condition for one of four residents (R1) in the sample. These failures resulted in R1 sustaining uncontrollable tremors, and uncontrolled sharp pain. Findings include; R1's history and physical states; (2/10/20) back pain status [REDACTED]. Rates pain 5/10 currently resting in bed. Did not take pain medications yesterday evening. (2/11/20) 3:37pm, Last night noted to have acute worsening with some sharper pains this morning. R1's POS (Physician order [REDACTED]. [MEDICATION NAME] 7.5-325mg (2 tablets) every 6 hours PRN for moderate pain. R1's (February 2020) Medication Administration Record [REDACTED]. [MEDICATION NAME] was not administered. R1's controlled substance proof of use affirms the last dost of [MEDICATION NAME] 7.5-325mg was administered on 2/10/20 at 5:30pm. (Quantity remaining was 0). R1's progress notes state; (2/11/20) 11:25pm, Writer noticed that patient was out of [MEDICATION NAME] pain medication and called pharmacy to get authorization to pull. Per pharmacy, no more [MEDICATION NAME] was available and writer was not able to administer medication as ordered. Patient needed new C2 form. (There is no documentation that the physician was notified of [MEDICATION NAME] availability, [MEDICATION NAME] administration and/or required C2 form). 11:06am, (approximately 12 hours later) Call placed to doctor's office to inform of reported redness and increased pain to lower incision, left message with call back requested. 3:59pm, (an additional 5 hours later) Patient will be sent to hospital for further assessment, showing symptom for uncontrollable tremors. 8:46pm, Spoke to emergency room nurse, patient has been admitted for uncontrolled pain. The (8/2018) new schedule II controlled substance medication orders policy states; new orders for Schedule II controlled drugs require a written prescription meeting DEA (Drug Enforcement Agency) requirements prior to dispensing or removal from Emergency Medication Supplies, unless there is an Emergency Situation. (as defined below). 1.) Where permitted under Applicable Law, Schedule II prescriptions for long term care residents, may be faxed to the pharmacy. The Ekit (Emergency Kit) contents include [MEDICATION NAME] 7.5-325mg tablet (Quantity 6). On 3/4/20 at 12:20pm, surveyor inquired if [MEDICATION NAME] is in the Ekit V2 (Director of Nursing) stated Yes. Surveyor inquired why R1 did not receive [MEDICATION NAME] as prescribed V2 responded They should have been able to call and get an order to pull [MEDICATION NAME]. On 3/5/20 at 1:20pm, V10 (Physician) stated if there's a change in condition they need to contact us, me or the Nurse Practitioner. Surveyor inquired if V10 was made aware that R1's [MEDICATION NAME] was unavailable V10 responded I don't recall that. Surveyor inquired about the potential harm if a post-operative patient experiencing pain does not receive [MEDICATION NAME] as prescribed V10 responded In terms of pain, being uncomfortable overall.
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.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based upon record review and interview the facility failed to ensure that prescribed medications were available for two of four residents (R1, R3) in the sample. Findings include; 1.) The (8/2018) new schedule II controlled substance medication orders policy states; new orders for Schedule II controlled drugs require a written prescription meeting DEA (Drug Enforcement Agency) requirements prior to dispensing or removal from Emergency Medication Supplies, unless there is an Emergency Situation. R1's POS (Physician order [REDACTED]. R1's controlled substance proof of use affirms the last dose of [MEDICATION NAME] was administered on 2/10/20 at 5:30pm. (Quantity remaining 0). R1's (2/11/20) progress note states; writer noticed that patient was out of [MEDICATION NAME] pain medication and called pharmacy to get authorization to pull. Per pharmacy, no more [MEDICATION NAME] was available. On 3/4/20 at 12:20pm, surveyor inquired why R1 did not receive [MEDICATION NAME] as prescribed V2 (Director of Nursing) responded They should have been able to call and get an order to pull [MEDICATION NAME]. 2.) The (2017) new orders for non-controlled substances policy and procedure states; if medication is needed before the next scheduled delivery and is not available in the Emergency Medication Supply, Facility staff should: Notify the pharmacy of the exact time by which the medication is needed. On 2/27/20 at 3:50pm, R3 stated About a week ago they were a little bit slow on getting the medication for this infection I had and advised it was not administered as ordered. R3's (2/11/20) physician orders [REDACTED]. R3's (February 2020) MAR (Medication Administration Record) affirms Micafungin was not documented as administered on 2/15/20 (blank) and 2/18/20 (see Nurse notes). R3's (2/18/20) progress notes state; Micafungin medication was unavailable.
F 0760 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Ensure that residents are free from significant medication errors.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based upon interview and record review the facility failed to administer significant medications as ordered for two of four residents (R1, R3) in the sample. Findings include; The (3/2010) medication administration policy & procedure states;

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.

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F 0760 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 1) administer medication in accordance with frequency prescribed by physician, within 60 minutes before or after prescribed dosing time. Document initials on MAR (Medication Administration Record) for each medication administered. 1.) R1's [DIAGNOSES REDACTED]. R1's ([DATE]) POS (Physician order [REDACTED]. R1's (2/11/20) progress note states; writer noticed that patient was out of [MEDICATION NAME] pain medication and called pharmacy to get authorization to pull. Per pharmacy, no more [MEDICATION NAME] was available and writer was not able to administer medication as ordered. On 3/4/20 at 12:20pm, surveyor inquired why R1 did not receive [MEDICATION NAME] as prescribed V2 (Director of Nursing) responded They should have been able to call and get an order to pull [MEDICATION NAME]. 2.) On 2/27/20 at 3:50pm, R3 stated About a week ago they were a little bit slow on getting the medication for this infection I had and advised it was not administered as ordered. R3's (2/11/20) physician orders [REDACTED]. R3's (February 2020) MAR (Medication Administration Record) affirms Micafungin was not documented as administered on 2/15/20 (blank) and 2/18/20 (see Nurse notes). R3's (2/18/20) progress notes state; Micafungin medication was unavailable.