STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145650	A. BUILDING _____ B. WING _____	**03/17/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
BRIA OF PALOS HILLS	**10426 SOUTH ROBERTS PALOS HILLS, IL 60465**

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 0552 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Ensure that residents are fully informed and understand their health status, care and treatments.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to follow their policy and practice in regards to discharge against medical advice by not providing or explaining the informed risk of leaving against medical advice for 1 of 3 (R1) reviewed for leaving against medical advice. Findings Include: R1 was admitted on [DATE] with the [DIAGNOSES REDACTED]. R1's brief interview for mental status dated 1/23/2020 document a scored of ten which indicated moderate impairment. Social Service note dated 2/21/20 at 11:09am: R1 was noted outside the building by staff entrance unauthorized. Staff reeducated R1 on the PASS policy and consequences of noncompliance. R1 left and refused to sign against medicate advice paperwork. R1 walked away. On 3/11/20 at 11:50am, V12 (Nurse) said, I was R1's nurse. I was passing medication. A code yellow was called. I didn't go outside. I was informed it was R1. It was cold outside. I didn't have R1 signed the Release of Responsibility Discharge Form because R1 was already gone. I signed the form after R1 left. On 3/11/20 at 1:25pm, V3 (Director of Nursing) said, social service should inform the resident of his risk of leaving AMA when given the Release of Responsibility Discharge Form. The nurse should be explaining the medical risk of missing treatment. It is my expectation for a nurse to break medication pass to intervene for any resident leaving against medical advice.
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 on observation, interview and record review the facility failed to follow their policy and ensure that medication was accounted for the controlled scheduled II medications for 3 of 3 (R4, R5, R6) reviewed for scheduled II accountability. Findings include: On 3/10/20 at 1:45pm, Medication cart observation with V11 (Nurse), R6's controlled drug receipt record/disposition form documented on 3/9 at 9pm, R6 had (23) twenty-three, [MEDICATION NAME] 50 mg left. R6's pill package/bingo card for [MEDICATION NAME] 50mg had (22) twenty-two pills in the package. On 3/10/20 at 1:46pm, V11 said, the narcotics must be signed out as soon as it is popped and counted at the beginning/ending of each shift. On 3/10/20 at 4:03pm, V3 (Director of Nursing) said, I expect the narcotic count to be balanced. On 3/11/20 at 3:23pm, V1 (Administrator) said, I haven't had any concerns with missing narcotics. On 3/11/20 at 4:37pm, V9 (Nurse) said, I was informed by V10 (Nurse) and V14 (Nurse), that some [MEDICATION NAME] where replaced with extra strength [MEDICATION NAME] and pill package/bingo card had tape on the back. I knew the pills in the package/bingo card was not [MEDICATION NAME]. [MEDICATION NAME] is not as long and thin as [MEDICATION NAME] which was the replacement pill with the tape on the back. On 3/11/20 at 4:49pm, V14 said, I was getting ready to pass a scheduled pain medication. When I popped the pill out, the pill stuck to the package. I turned it around and saw multiple pieces of tape on the back of the pill package/bingo card. The pill stuck to the tape was [MEDICATION NAME]. I notified V15 (Nurse Supervisor). On 3/12/20 at 1:06pm, V6 (Previous DON) said, I got a call from V9 (nurse), stating there was a discrepancy with the narcotics on 1/5/2020. I spoke with V8 (Nurse). V8 said, I gave the medication to another resident. I told V8, that borrowing medication was not the right thing to do. I didn't complete the final investigation. On 3/12/20 at 1:32pm, V3 said, I was informed that two nurses needed to be drug tested . I found out later, there was an issues with narcotics but I didn't know the specifics. In my practice, I would complete an investigation and notify the department of regulations about a discrepancy. On 3/12/20 at 1:52pm, V8 said, I am unaware about any missing narcotics. On 3/13/2020 at 1:27pm, V13 (Lead Pharmacy Consultant) said, the pharmacy was not updated in January 2020 about the narcotic discrepancy. R4's Controlled drug receipt record/disposition form document: [MEDICATION NAME]/[MEDICATION NAME] 10-325mg on 1/5 at 2pm with 18 (eighteen) pills left. On 1/6/20 documents: 15 (fifteen) pills left and wasted. R5's Controlled drug receipt record/disposition form document: [MEDICATION NAME]/[MEDICATION NAME] 10-325mg on 1/5 at 6pm with 15 (fifteen) pills left and on 1/6/20 documents: 10 (ten) pills left and wasted. Controlled Substance Medication policy dated 4/2018 documents Medication included in the Drug Enforcement Administration (DEA) classification as controlled substance are subject to special handling, storage, disposal and record keeping I the facility, in accordance with federal and state laws regulations. #6. B. Record each dose at the time of administration. C. Confirm the amount of controlled drug remaining is correct. #11. Irreconcilable discrepancies are documented by the Director of Nursing and reported to the Consultant Pharmacist and Administrator.

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.