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	145405	A. BUILDING _____ B. WING _____	C 08/03/2011

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F 000	INITIAL COMMENTS Complaint Investigation1171697/IL53164.	F 000		
F 167 SS=C	483.10(g)(1) RIGHT TO SURVEY RESULTS - READILY ACCESSIBLE A resident has the right to examine the results of the most recent survey of the facility conducted by Federal or State surveyors and any plan of correction in effect with respect to the facility. The facility must make the results available for examination and must post in a place readily accessible to residents and must post a notice of their availability. This REQUIREMENT is not met as evidenced by: Based on observation and interview the facility failed to have the most recent survey available to 3 of 4 residents in the sample and 189 residents in the facility. Findings Include: On 6/2/11 at 5:00 PM surveyor escorted to where survey book is kept. E1 (Administrator) present at this time. Last survey and complaint survey not in survey book. Interview with E1 stated , " I don't know what happened to it. There are K (architectural) Tags here. I'll find it. "	F 167		8/3/11
F9999	FINAL OBSERVATIONS FINAL OBSERVATIONS	F9999		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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F9999	Continued From page 1	F9999		

LICENSURE VIOLATIONS

300.1620a)
300.1630c)
300.1640a)
300.1640g)
300.1650d)1)2)
300.3240a)

Section 300.1620 Compliance with Licensed Prescriber's Orders

a) All medications shall be given only upon the written, facsimile or electronic order of a licensed prescriber. The facsimile or electronic order of a licensed prescriber shall be authenticated by the licensed prescriber within 10 calendar days, in accordance with Section 300.1810. All such orders shall have the handwritten signature (or unique identifier) of the licensed prescriber. (Rubber stamp signatures are not acceptable.) These medications shall be administered as ordered-by the licensed prescriber and at the designated time.

Section 300.1630 Administration of Medication

c) Medications prescribed for one resident shall not be administered to another resident.

Section 300.1640 Labeling and Storage of Medications

a) All medications for all residents shall be properly labeled and stored at, or near, the nurses' station, in a locked cabinet, a locked medication room, or one or more locked mobile

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F9999	Continued From page 2 medication carts of satisfactory design for such storage. g) Each single unit or unit dose package shall bear the proprietary or nonproprietary name of the drug, strength of dose and total contents delivered, lot or control number, and expiration date, if applicable. The names of the resident and the licensed prescriber do not have to be on the label of the package, but they must be identified with the package in such a manner as to assure that the drug is administered to the right resident. Appropriate accessory and cautionary statements and any necessary special instruction shall be included, as applicable. Hardware for storing and delivering the medications shall be labeled with the identity of the dispensing pharmacy. The pharmacist shall provide written verification of the date the medications were dispensed and the initials (or unique identifier) of the pharmacist who reviewed and verified the medications. The pharmacist need not store such verification at the facility but shall readily make it available to the Department upon request. The lot or control number need not appear on unit dose packages if the dispensing pharmacy has a system for identifying those doses recalled by the manufacturer/distributor or if the dispensing pharmacy will recall and destroy all dispensed doses of a recalled medication, irrespective of a manufacturer's/distributor's specifically recalled lot. Section 300.1650 Control of Medications d) Inventory Controls 1) For all Schedule II controlled substances, a controlled substances record shall be maintained	F9999		

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F9999	Continued From page 3 that lists on separate sheets, for each type and strength of Schedule II controlled substance, the following information: date, time administered, name of resident, dose, licensed prescriber's name, signature of person administering dose, and number of doses remaining. 2) The pharmaceutical advisory committee may also require that other medications shall be subject to such inventory records. Section 300.3240 Abuse and Neglect a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. These Regulations were not met ase evidenced by: Based on record review and interview 1 of 4 residents (R1) in the sample received morphine without a physician order. This resulted in R1 requiring hospitalization due to a low thready pulse and Mental Status Changes. As the result of this failure, R1 was sent to an acute care facility via Advanced Life Support van for unresponsiveness and a low thready pulse of 40. A urine toxicology report noted R1 with 1038ng/ml/ of Opiate in R1's urine. A blood toxicology report showed R1 with 9 ng/ml. of free Morphine in his blood. A usual range following a therapeutic dose of Morphine is 10-70 ng/mL Findings Include: 1. Based on a review of R1's medical record at the facility R1 never had a physician order for	F9999		

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F9999	Continued From page 4 Morphine. Based ona complaint investigation done at the facility on 3/21/11, the facility failed to have labels on identical white bottles of medication one that contained Lorazepam and another Morphine. R1 resided on the same floor these unlabeled medications were found. In addition, there was a discrepancy in the facility's records between morphine remaining and morphine destroyed. Review of R1's medical record at the facility R1 does have a physician order for Lorazepam. On 1/24/11 R1 was sent from the facility to the hospital via ALS (Advanced Life Support) ambulance for unresponsiveness and a pulse of 40. Review of the ambulance report showed R1 did not receive morphine in the ambulance en route to the hospital. The ambulance arrived at the facility at 11:55 AM, departed at 12:14 PM and arrived at the hospital at 12:21 PM. On 1/24/11, Z1 (R1's physician at facility and hospital) wrote an admission note about R1 at the hospital. This note reads in part that R1 was seen 3 days ago by Z1 and R1, "Is alert and doing well. However, this morning, the nurse called me that the patient (R1) was unresponsive, hypotensive, and bradycardic. The patient was transferred to a near by acute care facility emergency room where the patient(R1) indeed was unresponsive,but grimacing." Review of the hospital record on 1/24/11 R1 did not receive morphine while in the emergency room. At 2:45 PM, a urine toxicology report indicates R1 with 1038ng/ml of Opiate in R1's	F9999		

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urine. At 3:20pm a blood toxicology report shows R1 with 9 ng/ml. of free Morphine in his blood. A usual range following a therapeutic dose of Morphine is 10-70 ng/mL.

During interview on 6/2/11 per phone at 11:00 AM, Z4 (Dr. at the lab that performed toxicology reports for R1 on 1/24/11) stated, "9ng/ml of free morphine in blood is a definite indication you would expect if someone was given Morphine. Definitely not an overdose. The 1038ng/ml is an indication he received morphine. You can never really tell how much was received by testing urine. Urine testing just indicates patient received Morphine, but not how much."

During interview with Z1 (R1's MD at facility) on 6/9/11 per phone at 11:50 AM, Z1 stated, "He (R1) was comatose at the hospital. I never ordered Morphine for him. There was no Morphine given to him at the hospital. I received a call from them (the facility) that he was unresponsive. I went to the emergency room to see him and he was not responsive. The daughter did request a drug screen. Honestly I wouldn't have thought to do that. I thank God the daughter did. There were no cardiac causes for his unresponsiveness. I did order Ativan at the facility. I was told when things didn't go his way he becomes combative. He was to receive Ativan only when absolutely necessary. What is necessary for them is not necessarily necessary to me. Again Morphine was never ordered at the facility. He cannot tolerate even small doses of psychotropics. We worked hard to get him off that. Even with an antidepressant he goes into a coma. I saw him 2 or 3 days before this happened and he was fine."

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2. During survey tour on the morning of 2/23/11, the medication room of the second floor was checked for proper storage (safety and security) of controlled substances. During this time it was noted that many of the medications stored in the medication room refrigerator were lacking labels, or had labels that were blurred and unable to be read as to contents, ownership or expiration dates.

Staff was asked to identify the medications. Among these was a small white dropper bottle that only had a strip label running down the side. The preprinted portion of the label read Lot No., Filled by, and Exp. Date on the strip. The information that had been entered was obliterated. Blue ink smears were found where the information was to have been. None of the writing was legible. The bottle was not in the original container from the manufacturer and so the only positive thing one could identify was that it contained a red colored liquid. The bottle was in a small ziplock bag. Based on this bag, E2 identified it as Lorazepam. Once out of the bag, there was no accurate way to be sure what it was or when or to whom it was dispensed. Another medication was found in the same type of white bottle. This one was in a ziplock bag that E5 identified by the label on the bag as Morphine Sulfate. The bottle did not have a legible label and the bottle was the same as that used for Lorazepam which only added to the difficulty in identifying the improperly labeled medications. When brought to the attention of the Administrator E1, the pharmacy was called and a representative came out. This representative verified that the pharmacy had repackaged these

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medications from the manufacturers bottles and that they did in fact use the same bottles for different medications.

Further review of other medications in the refrigerator revealed more labeling problems. A brown dropper bottle with a pharmacy attached label (again illegible) inside of a plastic medication bottle with an affixed pharmacy label that was also not able to be clearly read for name, dosage, frequency. Staff identified it as belonging to R14. Another brown bottle packaged and labeled in the same manner as that of R14 was one identified as belonging to R10. R4 had a brown bottle that was packaged in the original carton from the manufacturer that also had illegible pharmacy labels on both the bottle and the carton.

Based on the labeling observations, E2 the DON (Director of Nursing) was asked about reconciling the medication counts and the disposal of medications after they are discontinued and /or the resident has expired. E2 explained that a proof of use sheet is kept for each controlled medication. She also explained that the facility keeps a log of medications destroyed at the facility when they can not be returned to the pharmacy.

Review of these logs showed that there were some blanks on the destruction log. One entry for R15 for Morphine Sulfate lacked the prescription number. Another entry for R12 for Bella Donna/Opium suppositories lacked the quantity of the medication being destroyed. The form was signed by two nurses that E2 identified as being two of the nurses from the pharmacy

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F9999	Continued From page 8 that were helping her destroy medications because there were so many stored in her office. A control sheet belonging to R12 for Morphine Sulfate 20mg/ml was reviewed. The sheet documents it was last used on 1/3/11. The sheet showed 4.87 ml remaining at that time. The entry on the destruction log dated 2/3/11 shows 3 ml destroyed. With more than a month between the last documented use and its destruction, the reason for the discrepancy is unclear. (A)	F9999		