STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145674	A. BUILDING ______ B. WING ______	C 01/26/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LEROY MANOR	509 SOUTH BUCK ROAD, PO BOX 149 LE ROY, IL 61752

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 431	Continued From page 7 controlled medications were only single locked until E2 would pick them up on 12/26/11. E2 stated that there was supposed to be three bottles of liquid Morphine, six bottles of liquid Methadone, 118 Morphine suppositories, and eight Methadone suppositories in that bag. E2 said that when she picked up the bag on Monday 12/26/11, E2 did not inventory all the medications to make sure they were all there. E2 said that she just glanced in the bag and noticed several bottles of medication. E2 then took the bag and locked it in her office. E2 said she and E4 should have checked each medication in the bag with each controlled count sheet to verify that all the medications were accounted for. E2 stated it was on 1/6/12 when the police came to the facility that they found out that there were no Morphine suppositories or Methadone suppositories in the bag. E2 said that they checked the refrigerator in the 200 hall medication room and found all the eight Methadone and 118 Morphine suppositories gone and unable to be accounted for.	F 431		
F9999	FINAL OBSERVATIONS LICENSURE VIOLATIONS 300.1210b) 300.1630c) 300.1640g) 300.3240a) Section 300.1210 General Requirements for Nursing and Personal Care b) The facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive resident care	F9999		

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F9999	Continued From page 8 plan. Adequate and properly supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident. Restorative measures shall include, at a minimum, the following procedures: 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 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	F9999		

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F9999	Continued From page 9 manufacturer's/distributor's specifically recalled lot. 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 requirements were not met as evidenced by: Based on observation, interviews, and record reviews the facility failed to keep one of three residents (R1) reviewed for medication administration in a sample of three from receiving a narcotic medication that was not ordered for R1. R1 was found in her room unresponsive, with labored breathing and an oxygen saturation level of 37%. Findings include: R1's current Admission Record dated 1/17/12 notes R1 to have a Diagnosis of Multiple Sclerosis. On 1/17/12 at 10:20 A.M. E2 (Director of Nursing) stated that R1 is alert and oriented. On 1/17/12 at 1:50 P.M. R1 stated that she is unable to use her extremities so she has to rely on staff to give her all of her medications. R1's Medication Administration Record dated 1/12 notes that R1 receives a Dulcolax suppository every other night. On 1/20/12 at 9:02 A.M. E9 (Certified Nurses Aide) stated that R1 was her resident on 1/3/12, on the night shift that R1 was sent to the hospital. E9 stated that she was doing bed check at approximately 4 or 4:15 A.M. on 1/3/12. E9 went into R1's room and found R1 unresponsive. E9	F9999		

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F9999	Continued From page 10 stated that she then immediately notified R1's nurse (E4/Licensed Practical Nurse). E9 stated that E4 was unable to arouse R1 and that when they got R1's first pulse oxygen saturation level it was 37%. On 1/18/12 at 7:25 A.M. E4/LPN stated that on 1/3/12 at approximately 4:15 A.M. E4 went to R1's room per E9's request. E4 stated that R1 was unresponsive with fixed pinpoint pupils. E4 stated that R1's breathing was very labored and that R1's pulse oxygen saturation level was in the 30s or 40s from what she could remember. E4 stated that she called 911 and R1 was sent to the hospital. E4 stated that she did give R1 a Dulcolax suppository earlier that night around 7:30 P.M. E4 stated that the Dulcolax suppositories were kept in the 200 medication room refrigerator, the same place R2's Methadone suppositories were kept. R2's face sheet printed on 1/17/12 noted that R2 was on Hospice prior to R2's death on 12/22/11. On 1/19/12 at 11:15 A.M. E2, Director of Nursing opened the 200 hall medication refrigerator and Dulcolax suppositories were noted to be that refrigerator. E2 stated that the Methadone suppositories had been kept in this same refrigerator when they were in the facility. On 1/19/12 at 8:54 A.M. E7 (Licensed Practical Nurse) stated that the last time she had seen the Methadone suppositories in the 200 hall refrigerator was on 1/2/12, but there was no narcotic count sheet for the Methadone. Emergency Ambulance service records dated	F9999		

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F9999	Continued From page 11	F9999		

1/3/12 note that they responded to E4's call and arrived in R1's room at 4:39 A.M. Ambulance report notes that R1 was unresponsive and on four liters of oxygen. The Emergency Service staff immediately increased R1's oxygen to 15 liters, but R1 did not respond. Two milligrams of Narcan (a narcotic antagonist which is used to reverse the effects of narcotics) was then given to R1. According to the ambulance record, R1 responded to the Narcan and "started coming around and waking up. Pupils started becoming larger and pt. (R1) able to talk now." Ambulance records note that R1 arrived at hospital at 5:11 A.M. on 1/3/12.

Hospital Emergency Department records dated 1/3/12 note that R1 presented to them with a "Chief Complaint of altered mental status." Hospital records note that R1 remained in the hospital until discharged back to facility on 1/16/12.

On 1/18/12 at 1:00 P.M. Z2 (R1's Niece and a Registered Nurse) stated that R1 had a change in condition several times in the hospital where her breathing and blood pressure would drop and a Narcan Intervenous Drip had to be used.

The Hospital Comprehensive Drug Screen dated 1/4/12 noted that R1 tested positive for Methadone being detected in R1's blood system.

R1's Physician's order sheet dated 1/12 notes that R1 did not have an order for Methadone.

On 1/18/12 at 3:50 P.M. Z3 (R1's Attending Physician) stated that he become aware that R1 tested positive for Methadone at the hospital. Z3

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F9999	Continued From page 12	F9999		

stated that R1 has never had an order for Methadone, but must have gotten it somehow since R1 is unable to give herself medications.

On 1/19/12 at 8:47 A.M. Z1 (Facility's contracted Pharmacist) stated that he comes in once a month and destroys discontinued narcotics with E2/Director of Nursing. Z1 stated that from the time the Methadone and Morphine suppositories were delivered to the facility on 12/15/11 until the time of interview, he did not destroy any Methadone or Morphine suppositories.

On 1/20/12 at 9:45 A.M. Z4 (Hospice Manager) stated that once the hospice pharmacy delivers a resident's narcotics the facility becomes responsible for passing the medications to the resident and also for destroying the medications once they are discontinued. Z4 stated that the hospice staff would not have had any access to the facility's medication room where the Methadone suppositories were kept, so there is no way the hospice staff could have taken them or destroyed them.

On 1/20/12 at 1:30 P.M. E2/Director of Nursing stated that the local police came to the facility on 1/6/12 and that is when the facility first found out that R2 had eight Methadone suppositories and 118 Morphine suppositories that were unaccounted for. E2 stated that R2 had died on 12/22/11 and that E2 received a call on 12/23/11 from E4 stating that E4 had placed all of R2's narcotics and narcotic count sheets in a blue bag and left them in the 200 hall medication room for E2. E2 stated that she came into work on 12/26/11, grabbed the blue bag and looked inside. E2 said she could see several bottles of

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F9999	Continued From page 13 medications and count sheets, but she never checked to make sure all the narcotics were accounted for. E2 said she then locked them in her office. E2 stated at this time that she was unaware of the missing Methadone and Morphine until the police investigation took place. E2 stated that E4 should have checked each narcotic medication with each narcotic count sheet and then placed all of them in the bag. E2 said that when E2 then picked up the bag on 12/26/11 she should have then done those same checks to verify that all the narcotics were accounted for. E2 stated that the Methadone suppositories and Morphine suppositories were never double locked as required and that it was not until after this investigation started that a lock was put on the refrigerators in the medication rooms. On 1/18/12 at 1:20 P.M. R1 stated that she is having problems sleeping now because she is scared she is going to get the wrong medications. (B)	F9999		