STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145885	A. BUILDING _____ B. WING _____	C 04/14/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAYFIELD CARE CENTER	**5905 WEST WASHINGTON CHICAGO, IL 60644**

(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 000	INITIAL COMMENTS Complaint Investigation 1681907/IL84667 1681923/IL84691 - F309	F 000		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review the facility failed to follow their medication administration policy and ensure that the physician ordered dose of Guaifenesin ER was administered, and that Norco, Ambien, and Tramadol were available for administration for 1 of 3 residents R5 reviewed for medication administration policy. Findings Include: R5's Physician Order Sheet dated April 2016 includes the following orders: Tramadol HCL 50 milligrams (mg) 1 tablet Oral as needed four times maximum, docu liquid 50mg/5 ml (10 ml) oral every one day, Guaifenesin ER 600 mg one tablet Extended Release 12 hour oral two times daily, Norco 5 - 325 mg one tablet oral	F 309		

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

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F 309	Continued From page 1 as needed every six hours and Ambien 5 mg one tablet oral as needed hour of sleep. On 4/13/16 at 10:38 am with E3 Assistant Director of Nursing (ADON) R5 medication was reviewed in the medication cart. R5's Guaifenesin ER 600 mg tablet, dock liquid, tramadol HCL 50 mg tablet, Norco 5-325 mg tablets and Ambien 5 mg tablets were not observed in the medication cart. E4 Registered Nurse (RN) stated that R5's Guaifenesin was never delivered to the facility from the pharmacy. E3 stated that if narcotics are not used within 14 days they are returned to the pharmacy because it indicates that the resident does not need the medication. R5's Medication Administration Record (MAR) dated April 2016 indicates that R5 received Guaifenesin ER 600 mg on 4/13/16 at 9:00 am. R5's MAR indicates that R5 received docu liquid 10 ml on 4/13/16 at 9:00 am. R5's MAR indicates that R5 received Norco 5-325 mg 1 tablet on 4/7/16. On 4/13/16 at 11:45 am Z3 Pharmacist stated that R5's Norco, Tramadol and Ambien were not delivered to the facility because Physician approval is still pending. Z3 stated that R5's Guaifenesin ER 600 mg was not delivered to the facility because it is considered house stock and the facility provides the medication. The facility could not provide Guaifenesin ER 600 mg when requested by this surveyor. On 4/13/16 at 12:38 E4 Registered Nurse stated that he is not sure whether he administered docusate tablet or liquid to R5 on 4/13/16 at 9:00	F 309		

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F 309	Continued From page 2	F 309		

am. E4 stated that he administered house stock Guaifenesin to R5 on 4/13/16 at 9:00 am. When asked to show this surveyor which medication R5 was given E4 walked past the medication cart into a supply room near the nursing station and removed a bottle of Guaifenesin 400 mg tablets from the top cabinet in the supply room. E4 stated that he gave R5 one tablet of Guaifenesin. The medication provided by E4 was observed to be the incorrect dose and was not labeled as extended release as ordered on R5's POS.

R5's April 2016 MAR includes documentation indicating R5 received Guaifenesin ER 600 mg twice daily on 4/2/16, 4/3/16 and 4/5/16 - 4/11/16.

On 4/13/16 at 11:15 with E3 ADON and E10 Central Supply Clerk in the Central Supply Area Guaifenesin ER 600 mg was not available in the facility.

On 4/14/16 at 9:15 am E7 Licensed Practical Nurse (LPN) stated that on 4/7/16 she borrowed Norco from R10 to give to R5 because he was complaining of pain and not being able to sleep. E7 stated that R5's Ambien was also not available. R10's controlled drug receipt/record/disposition form dispensed 3/14/16 indicates that on 4/7/16 one Norco tablet was signed out and documented as borrowed. E7 stated that she was not aware that she should not borrow medication from one resident to use for another.

The facility's Medications Administration policy revised 8/2015 indicates that medication in the medication cart are only to be administered to the resident for whom the medication was prescribed, medications may not be "borrowed" for other

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F 309	Continued From page 3 residents. The policy also indicates that the nurse should read medication carefully before preparing dose, check label, packaging and actual medication for consistency with MAR. If inconsistencies are noted, the medication should not be administered until issue is clarified with the pharmacist. This policy was not followed.	F 309		