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	145294	A. BUILDING ______ B. WING ______	C 01/26/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRAIRIE VILLAGE HEALTHCARE CTR	1024 WEST WALNUT JACKSONVILLE, IL 62650

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F 000	INITIAL COMMENTS Complaint #1640253/IL82741	F 000		
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review the facility failed to administer a residents own medication and failed to observe a resident take medication for 2 of 22 residents (R10, R16) in the sample of 22. Findings include: 1. On 1/19/16 at 11:15 AM, E3 Licensed Practical Nurse (LPN) could not find R10's Seroquel 25 milligrams (mg) in the medication cart. E3 stated "I don't know where the medicine is, I know it was ordered." E3 looked in the other medication cart and could not find R10's medicine in the other cart. E3 then said "I know who else takes that, I will borrow one from that resident." E3 took 25 mg Seroguel from R13's medication and gave it to R10. On 1/21/15 at 12:00 PM, E2 Director of Nurses (DON), stated R3 should not have borrowed a medication from one resident to give to another, she should have gotten one from the locked box, and notified the pharmacy. E2 stated she found R10's Seroquel later after E3 had already given R13's medication to R10. E2 stated she found R10's medication in the medicine cart where it	F 281		

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 281	Continued From page 1 was supposed to be but E3 just didn't see it. The facility's Policy and Procedure for Medication Administration, dated 11/3/14 documented, Procedures, 11) If a medication with a current, active order cannot be located in the medication cart/drawer, other areas of the medication cart, medication room and facility (e.g., other units) are searched, if possible. If the medication cannot be located after further investigation, the pharmacy is contacted or medication is removed from the night box/emergency kit. Administration, 15) Medications supplied for one resident are never administered to another resident. 2. On 1/19/16 at 11:27 AM, E3 put Ultram 50 mg in a medication cup and took it to the dining room and placed it on the table where R16 was sitting. E3 then turned around and walked out of the dining room. E3 did not watch R16 take the medication. The facility's Policy and Procedure for Medication Administration dated 11/3/14 documented, Administration, 18) The resident is always observed after administration to ensure that the dose was completely ingested. If only a partial dose was ingested, this is noted on the medication administration record (MAR), and action is taken as appropriate.	F 281		
F 323 SS=E	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.	F 323		

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F 323	Continued From page 2	F 323		

This REQUIREMENT is not met as evidenced by:
Based on observation and record review the facility failed to provide adequate supervision by leaving an unlocked medication cart unattended. This has the potential to affect 9 residents (R2, R10, R11, R17, R18, R19, R20, R21, R22), who are mobile and cognitively impaired who might have had access to the unattended medication cart.

Findings include:

1. On 1/19/16 at 11:10 AM, E3 left the medication cart at the nurses station unlocked, while she went to look for a medication down the hall in another medication cart. The medication cart that was left unattended had a bubble pack of Entacapone 200 mg, laying on top of the medication cart. There were 60 tablets in the bubble pack.

2. On 1/19/16 at 11:47 AM, E3 left the medication cart unlocked at the nurses station and went into the dining room to give a medication. The unlocked medication cart that was left unattended had a bottle of liquid Potassium Chloride sitting on top of the cart.

On 1/20/16, E1 provided a list of residents on the 100 and 200 hallways who were mobile and cognitively impaired. Those residents were R2, R10, R11, R17, R18, R19, R20, R21 and R22 who all could have had access to the unattended medication cart.

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F 323	Continued From page 3 The facility's Policy and Procedures for Medication Administration dated 11/3/14 documented, B. Administration, 16) During Administration of medications, the medication cart is kept closed and locked when out of sight of the medication nurse or aide. No medications are kept on top of the cart. The cart must be clearly visible to the personnel administering medications, and all outward sides must be inaccessible to residents or others passing by. In addition, privacy is maintained at all times for all resident information (e.g., MAR) [by closing the MAR book/covering the MAR sheet or computer screen] when not in use.	F 323		
F 332 SS=D	483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE The facility must ensure that it is free of medication error rates of five percent or greater. This REQUIREMENT is not met as evidenced by: Based on observation, record review and interview the facility failed to administer medication at the time ordered, failed to have an order for a medication administered and failed to observe a resident swallowing a medication given. There were 29 opportunities with 3 errors resulting in a 10.3% medication error rate. The errors involved three residents (R14, R15, R16) in the sample of 22. Findings include: 1. On 1/19/16 at 11:25 AM, E3 Licensed Practical	F 332		

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Nurse (LPN) during a medication pass for R15, stated "I am going to give her some Tylenol too, because if I don't bring it she will ask for it, then I will just have to come back to the medication cart and get it and bring it back to her." E3 put two Mapap (Acetaminophen) 325 milligrams (mgs) in the medication cup along with Gabapentin 400mgs, Dicyclomine 20 mg, Albuteral 2 mg, brought them to the dining room and gave them to R15.

The Physicians Order Sheet (POS) for R15, dated 1/1/2016 through 1/31/16, documented no orders for R15 to recieve Mapap.

R15's Medication Administration Record (MAR) does not document E3 giving Mapap to R15. R15's nurses notes does not document E3 giving R15 Mapap.

The facility's Policy and Procedure dated 11/3/14, documented, B. Administration, 2) Medications are administered in accordance with written orders of the prescriber.

2. On 1/19/16 at 11:27 AM, E3 put Ultram 50 mg in a medication cup and took it to the dining room and placed it on the table where R16 was sitting. E3 then turned around and walked out of the dining room. E3 did not watch R16 take the medication.

The facility's Policy and Procedure for Medication Administration dated 11/3/14 documented, Administration, 18) The resident is always observed after administration to ensure that the dose was completely ingested. If only a partial dose was ingested, this is noted on the medication administration record (MAR), and

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F 332	Continued From page 5 action is taken as appropriate. 3. On 1/19/16, at 11:40 AM, observed R14's medications administration by E9, Licensed Practical Nurse, (LPN). E9 administered, Potassium Chloride ER 20 meq (milliequivalent)-one tablet by mouth, Clonidine 0.2 mg (milligram)-one tablet by mouth, Humulin R insulin-15 units subcutaneous, and Duoneb 2.5-0.5mg/3ml (milliliter)-one vial inhalation. R14's Physician Order Sheet (POS) dated, 1/1/16 -1/31/16 documents these medications to be administered during the noon medication pass, "Demadex 20 mg, two tablets (40 mg) by mouth twice daily at 6 AM and NOON, Potassium Chloride ER 20 meq-one tablet by mouth four times daily, Clonidine HCL 0.2 mg-one tablet by mouth three times daily, Humulin Regular Insulin-inject 15 units subcutaneously four times daily, and Duoneb 2.5-0.5mg/3ml-one vial inhalation per nedulizer four times a day." Review of R14's Medication Administration Record (MAR) dated 1/19/16, Noon, Demadex 20 mg, two tablets (40 mg), was not documented as administered. R14's chart face sheet documents diagnosis dated 8/16/15, Hypertension, Acute Kidney Failure, Pulmonary Fibrosis, Cellulitis of unspecified part of limb, Chronic Obstructive Pulmonary Disease... Interview on 1/19/16 at 1:15 PM, E9 stated, "I did not give (R14) her Demadex, I just missed it. I will call the doctor and let him know."	F 332		
F 425 SS=E	483.60(a),(b) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH	F 425		

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The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse.

A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident.

The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility.

This REQUIREMENT is not met as evidenced by:
Based on observation, interview and record review, the facility failed to administer medications as ordered and follow facility policy for 5 of 9 residents, (R4, R7, R9-14, R16) reviewed for medication administration.

Findings include:

1. On 1/19/16 at 11:15 AM, E3 Licensed Practical Nurse (LPN) could not find R10's Seroquel 25 milligrams (mg) in the medication cart. E3 stated "I don't know where the medicine is, I know it was ordered." E3 looked in the other medication cart and could not find R10's medicine in the other

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cart. E3 then said "I know who takes that, I will borrow one from that resident." E3 took 25 mg Seroguel from R13 and gave it to R10.

On 1/21/15 at 12:00 PM, E2 Director of Nurses (DON), stated R3 should not have borrowed a medication from one resident to give to another, she should have gotten one from the locked box, and notified the pharmacy. E2 stated she found R10's Seroquel later after E3 had already given R13's medication to R10. E2 stated R10's medication was in the medicine cart where it was supposed to be but E3 just didn't see it.

2. On 1/19/16, at 11:40 AM, observed R14's medications administration by E9, Licensed Practical Nurse, (LPN). E9 administered, Potassium Chloride ER 20 meq (milliequivalent)--one tablet by mouth, Clonidine 0.2 mg-one tablet by mouth, Humulin R insulin-15 units subcutaneous, and Duoneb 2.5-0.5mg (milligram)/3ml (milliliter)-one vial inhalation.

R14's Physician Order Sheet (POS) dated, 1/1/16 -1/31/16 documents these medications to be administered during the noon medication pass, Demadex 20 mg, two tablets (40 mg) by mouth twice daily at 6 AM and NOON, Potassium Chloride ER 20 meq-one tablet by mouth four times daily, Clonidine HCL 0.2 mg-one tablet by mouth three times daily, Humulin Regular Insulin-inject 15 units subcutaneously four times daily, and Duoneb 2.5-0.5mg/3ml-one vial inhalation per nedulizer four times a day.

Review of R14's Medication Administration Record (MAR) dated 1/19/16, Noon, Demadex 20 mg, two tablets (40 mg), was not documented as administered.

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R14's chart face sheet documents diagnosis dated 8/16/15, Hypertension, Acute Kidney Failure, Pulmonary Fibrosis, Cellulitis of unspecified part of limb, Chronic Obstructive Pulmonary Disease...

3. R9's Physician Order Sheet (POS) dated, 1/1/16 -1/31/16 documents these medications to be administered during the 9:00 AM medication pass, Amlodipine 5 mg-1 by mouth daily, Probiotic-one tablet by mouth twice daily, Metformin 500 mg-one tablet by mouth twice daily, Aspirin 81 mg-chew one by mouth daily, Iron 325 mg-one tablet by mouth daily, Gabapentin 300 mg-one tablet by mouth three times daily, Omeprazole 20 mg-one capsule by mouth daily, Zantac 150 mg-one tablet by mouth twice daily, Vitamin C 500 mg-one tablet by mouth daily, and Effexor ER 150 mg-one tablet by mouth daily.

Review of R9's MAR, on 1/20/16 at 9:30 AM, all 9:00 AM medications on the MAR did not contain documentation medications were administered.

Interview on 1/20/16 at 8:45 AM, E4 stated, "I finished my medication pass at 8:42 AM." On 1/20/16 at 1:30 PM, E4 stated, I did not check the MAR for (E9's) medications. I did not give (R9) her medications."
E5 stated on 1/21/16 at 7:56 AM, "I did not administer (R9's) 8:00 AM or 9:00 AM medications yesterday. I only gave R9 her 6:00 AM insulin."

4. R4's Physician Order Sheet (POS) dated, 1/1/16 -1/31/16 documents, Dexamethasone 4 mg-take 2 tablets twice on the day before, day of,

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and day after chemo at 9:00 AM and 5:00 PM..

R4's chart face sheet documents diagnosis dated 12/17/16, Secondary malignant neoplasm of unspecified site, Abnormal findings of lung field, Pneumonia, Hypertension, Hypokalemia, Hyperlipidemia...

Review of R9's MAR, on 1/20/16 at 10:30 AM, Dexamethasone 4 mg-2 tablets at 9:00 AM did not contain documentation medication was administered.
Review of the MAR documents Dexamethasone 4 mg- 2 tablets was to be administered at 9:00 AM and 5 PM on 1/18/16, 1/19/16 and 1/20/16. There was no documentation medication was administered on 1/18/16 or 1/20/16 at 9:00 AM.

Interview on 1/20/16 at 1:30 PM, E4 stated she did not administer the 9:00 AM dose on 1/20/16. On 1/21/16 at 9:45 AM, E8, LPN, stated she did not administer the 9:00 AM dose of medication on 1/18/16.

Interview on 1/20/16 at 11:00 AM, Z1, Physician, stated, "It is not a significant medication error with (R4) not getting his Dexamethasone as prescribed for those 2 doses."

5. R12's POS dated 1/1/16 -1/31/16, documents medications to be administered at 8:00 AM, Lasix 20 mg-one tablet by mouth once daily, Docusate Sodium 100 mg-one capsule by mouth twice daily, Erythromycin Eye Ointment 0.5%-apply topically to both eyes four times a day, Mucinex ER 600 mg-one tablet by mouth twice daily, I-Vite-two tablets by mouth daily, Toprol XL 25 mg-one tablet by mouth daily, K-Dur 20 meq-one tablet by mouth daily, Spiriva 18 mcg

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F 425	Continued From page 10 CP-handihaler-inhale contents of 1 capsule, Lorazepam 0.5 mg-one tablet by mouth twice daily, Levaquin 500 mg one by mouth daily, and Tobramycin eye drops-two drops ou (both eyes) four times a day. Review of R12's MAR, on 1/20/16 at 9:30 AM, all 8:00 AM medications on the MAR did not contain documentation medications were administered. R12's chart face sheet documents diagnosis dated 1/11/16, Pneumonia, Sepsis, Urinary Tract Infection Interview on 1/20/16 at 1:30 PM, E4, LPN, stated, "I did not give (R12) her medication, E5 told me she did." On 1/21/16 at 8:00 AM, E5 stated, "I gave (R12) her medication, I just didn't sign the medications off on the MAR." On 1/20/16 at AM, R12 stated, "The nurse with the glasses (R12) gave me my medicine this morning." 6. R7's POS dated 1/1/16 -1/31/16, documents medications to be administered at 9:00 AM, Norvasc 10 mg-one tablet by mouth daily, Aspirin 325 mg-one tablet by mouth daily, Tenormin 100 mg-one tablet by mouth daily, Cardizem CD 120 mg-one tablet by mouth daily, Docusate Sodium 100 mg-one capsule by mouth twice daily, Lexapro 20 mg-one tablet by mouth once daily, Lasix 40 mg one tablet by mouth twice daily, Hydralazine 10 mg one tablet by mouth three times daily, Glucophage 500 mg-one tablet by mouth twice daily, Ditropan XL 10 mg one tablet by mouth twice daily, Topamax 100 mg one tablet by mouth twice daily, and Topamax 50 mg one	F 425		

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F 425	Continued From page 11 tablet by mouth twice daily. Review of R7's MAR, on 1/20/16 at 9:30 AM, all 9:00 AM medications on the MAR did not contain documentation medications were administered. Interview on 1/20/15 at 11:00 AM, R7 stated, "(E4) gave me my medication in the dining this morning, I was still eating and I don't take my medicine until I'm done eating so she left them on my tray for me to take later when I'm done eating. My stomach doesn't like to take medication until I'm done eating. When I was done eating, I took my medicine. (E4) just leaves the medicine and goes on to give other people their medicine." On 1/20/16 at 1:30 PM, E4 stated, "I gave (R7) her medication in the dining room. I did not leave her medicine on her tray, I watched her take it. I just didn't sign off on the MAR that I gave her medication." 7. R13's POS dated 1/1/16 -1/31/16, documents medications to be administered at 9:00 AM, Prozac 40 mg-one capsule by mouth once daily, Lasix 20 mg-one tablet by mouth daily, Aspirin 81 mg-One tablet by mouth daily, Cetirizine HCL 10 mg-one tablet by mouth twice daily, Docusate Sodium 100 mg-one capsule by mouth twice daily,Lisinopril 2.5 mg-one tablet by mouth daily, Glucophage 1000 mg-one tablet by mouth twice daily, Prilosec 20 mg-one tablet by mouth daily, Seroquel 25 mg-one tablet by mouth twice daily, and Vitamin B-12-one tablet by mouth daily. Review of R13's MAR, on 1/20/16 at 9:30 AM, all 9:00 AM medications on the MAR did not contain documentation medications were administered.	F 425		

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On 1/20/16 at 1:30 PM, E4 stated, "I gave R13 her medication, I just didn't sign off on the MAR" R13 is not interviewable.

8. R11's POS dated 1/1/16 -1/31/16, documents medications to be administered at 8:00 AM, Norco 5-325-one tablet by mouth three times daily and medications to be administered at 9:00 AM., Aspirin EC 81 mg-one tablet by mouth every morning, Lexapro 20 mg-one tablet by mouth every morning, Keppra 1000 mg-one tablet by mouth twice daily, Metoprolol 25 mg-one tablet by mouth twice daily, K-Dur 20 Meq-one tablet by mouth every morning, and Zantac 150 mg-one tablet by mouth twice daily.

Review of R11's MAR, on 1/20/16 at 9:30 AM, all 8:00 AM and 9:00 AM medications on the MAR did not contain documentation medications were administered.

On 1/20/16 at 1:30 PM, E4 stated, "I gave R11 his medications, I just didn't sign off on the MAR off."
On 1/20/15 at 11:10 AM, R11 stated, "I got my medications this morning."

On 1/20/16 at 1:15 PM, E1, Administrator stated, "If the night nurse and who's passing the morning medications doesn't sign off on the MAR, how does the day nurse coming on shift know if the medications were administered or not. There is a very good possibility the resident could get double the medications, no medications, or the right medications.

On 1/20/16 at 1:15 PM, E2, stated, "The nurses

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	145294	A. BUILDING ______ B. WING ______	C 01/26/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRAIRIE VILLAGE HEALTHCARE CTR	1024 WEST WALNUT JACKSONVILLE, IL 62650

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know they are supposed to pass medications as prescribed and sign off on the MAR's after they give their medications. These are seasoned nurses, they know better.

On 1/20/16, E1 and E2 were present during interview with E4.

9. Facility Policy IIA2: Medication Administration, dated 11/03/14, Procedures,
A. Preparation, 11) If a medication with a current, active order cannot be located in the medication cart/drawer, other areas of the medication cart, medication room, and facility (e.g., other units) are searched, if possible. If the medication cannot be located after further investigation, the pharmacy is contacted or medication removed from the night box/emergency kit.

B. Administration 2) Medications are administered in accordance with written orders of the prescriber.
15) Medications supplied for one resident are never administered to another resident.

D. Documentation 1) The individual who administers the medication dose records the administration on the resident's MAR directly after the medication is given. At the end of each medication pass, the person administering the medications reviews the MAR to ensure necessary doses were administered and documented. In no case should the individual who administered the medications report off-duty without first recording the administration of any medications.

F 431 SS=E 483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS F 431

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The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.

Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.

In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.

The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.

This REQUIREMENT is not met as evidenced by:
Based on observation and record review the facility failed to secure all medication in a locked

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F 431	Continued From page 15 area and failed to observe a resident taking medication during a medication pass, this has the potential to affect 9 residents (R2, R10, R11, R17, R18, R19, R20, R21 and R22) who are mobile and cognitively impaired and 1 resident (R16) who was not observed swallowing her medication in the sample of 22. 1. On 1/19/16 at 11:10 AM, E3 left the medication cart at the nurses station unlocked, while she went to look for a medication down the hall in another medication cart. The medication cart that was left unattended had a bubble pack of Entacapone 200 mg, laying on top of the medication cart. There were 60 tablets in the bubble pack. 2. On 1/19/16 at 11:47 AM, E3 left the medication cart unlocked at the nurses station and went into the dining room to give a medication. The unlocked medication cart that was left unattended had a bottle of liquid Potassium Chloride sitting on top of the cart. On 1/20/16, E1 provided a list of residents on the 100 and 200 hallways who were mobile and cognitively impaired. Those residents were R2, R10, R11, R17, R18, R19, R20, R21 and R22 who all could have had access to the unattended medication cart. 3. The facility's Policy and Procedures for Medication Administration dated 11/3/14 documented, B. Administration, 16) During Administration of medications, the medication cart is kept closed and locked when out of sight of the medication nurse or aide. No medications are kept on top of the cart. The cart must be clearly visible to the personnel administering	F 431		

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F 431	Continued From page 16 medications, and all outward sides must be inaccessible to residents or others passing by. In addition, privacy is maintained at all times for all resident information (e.g., MAR) [by closing the MAR book/covering the MAR sheet or computer screen] when not in use. 4. On 1/19/16 at 11:27 AM, E3 put Ultram 50 mg in a medication cup and took it to the dining room and placed it on the table where R16 was sitting. E3 then turned around and walked out of the dining room. E3 did not watch R16 take the medication. 5. The facility's Policy and Procedure for Medication Administration dated 11/3/14 documented, Administration, 18) The resident is always observed after administration to ensure that the dose was completely ingested. If only a partial dose was ingested, this is noted on the medication administration record (MAR), and action is taken as appropriate.	F 431		