STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145734	A. BUILDING ______ B. WING ______	03/18/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VILLA AT EVERGREEN PARK,THE	10124 SOUTH KEDZIE EVERGREEN PARK, IL 60805

(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 Annual Licensure and Certification Survey	F 000		
F 309 SS=E	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 assess and monitor pain; failed to obtain parameters for the use of pain medication for residents; failed to document the administration of pain medication; and failed to evaluate the effectiveness of pain medication after administration. The facility also failed to have integrated communication between the facility and the dialysis unit, and failed to monitor and assess the status of the resident post dialysis. The facility also failed to document and obtain information to properly monitor pacemaker function. This applies to 5 of 24 residents (R4, R15, R17, and R24) reviewed for pain, dialysis, and pacemakers in the sample of 24. 1. R4 had diagnoses including Mild Mental Retardation, Closed Fracture of Ankle, Anemia and Hip joint replacement. R4 was readmitted on 2/28/15 after Hip revision.	F 309		

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145734	A. BUILDING ______ B. WING ______	03/18/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 309	Continued From page 1 R4's MDS (Minimum data Set) dated 03/07/15 showed that R4's BIMS score (Brief Interview for Mental Status) was 1 meaning R4 has severe cognitive impairment. R4 was observed on 03/15/15 up in the wheelchair in the initial tour. At 1:10 pm R4 was in bed and the right hip area of the pants were wet with drainage. The cloth incontinent pad on the bed was also wet with drainage. While checking the drainage with E4 (Wound Nurse), R4 was observed grimacing when touched on the hip area. E4 stated she had changed R4's wound dressing and told a CNA (Certified Nursing Assistant) to change R4's pants but the CNA ' s were passing lunch trays at the time. The following day on 03/16/15, E5 (Wound Nurse) changed R4's wound dressing and R4 was observed grimacing and moaning when the site was touched. March 2015 POS (Physician Order Sheet) showed R4 had an order for Norco 5/325 mg (Two tablets) every four hours as needed for pain and Tylenol 650 mg every six hours as needed for pain. The orders did not have parameters to differentiate when to use the Norco or when to use the Tylenol. R4 ' s Comprehensive pain assessment dated 02/28/15 done after readmission omitted Tylenol as an intervention for pain control and no parameters were set to determine which medication to use for pain control interventions. Nurses notes dated 03/05/15 at 15:54 (3:54 PM) showed " The resident's hip incision has changed in status she is having a moderate amount of serosanguinous drainage, there is increased	F 309		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145734	A. BUILDING ______ B. WING ______	03/18/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VILLA AT EVERGREEN PARK,THE	**10124 SOUTH KEDZIE** **EVERGREEN PARK, IL 60805**

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F 309	Continued From page 2	F 309		

swelling and she is complaining of pain."

On 03/16/15 at 3:15 PM, E18 (Nurse) said she was the treatment nurse on 03/05/15. She said R4 had complained of pain in the right hip and E18 had told R4 ' s nurse.

Review of R4 ' s Controlled Substance Proof of use for Norco showed E6 (Nurse) had signed out two tablets on 03/05/15 at 10 AM but there was no documentation in the MAR or nurses notes that it was given. No assessment of R4's pain, nor a follow up after the medication administration was found on the MAR for 03/05/15 at 10am.

Review of R4's Controlled Substances Proof of Use sheet showed E6 (Nurse) had signed out Norco medication on the following dates:
02/28 at 10pm-2 tablets,
03/01 at 9 AM- 2 tablets,
03/01 at 1 PM- 2 tablets,
03/01 at 6 PM-1 tablet,
03/03 at 6 AM- 2 tablets,
03/03 at 12 PM- 2 tablets,
03/03 at 4 PM- 2 tablets,
03/03 at 10 PM- 2 tablets,
03/05 at 10 AM 2 tablets.
No comments were written on the comments section, no parameters documented and no follow up provided if pain medication were actually given. No documentation on R4's MAR (Medication Administration Record) dated March 2015 was found to show that the medications for pain.

On 03/17/15 at 12:40 PM E6 was asked about the medications that was signed out from R4's Norco medication bingo card. E6 acknowledged that she signed out all the medications for R4. E6

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145734	A. BUILDING ______ B. WING ______	03/18/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 309	Continued From page 3 did not sign on R4's MAR that these narcotic pain medication were given. E6 was unable to answer the type of parameters she followed nor show if staff followed up on the effectiveness of medication if they were given. R4's pain management care plan interventions included: Administer analgesia as per order, Identify and record previous response to analgesia including pain relief, side effects and impact on function, Monitor and document for probable cause of each pain episode. R4's clinical record showed these interventions were not followed. R4 was not assessed regularly to check whether she had pain and was not given medication when she was in pain. R4 was observed grimacing while being checked by E4 (wound nurse) on 3/15 and grimacing and moaning while being given wound treatment on 3/16 by E5. The MAR did not show if R4 received any pain medication and there was no record of follow up to check if pain was relieved. R4's admission pain assessment indicated R4 had mild Mental Retardation and can express pain by facial expression, guarding, moaning loudly or crying. The assessment showed wound dressing and repositioning made the pain worse. There was no documentation of these being monitored on a regular basis. 2. R15 had diagnoses including Right hip Fracture S/P Arthroplasty, both Lower Extremity DVT (Deep Vein Thrombosis), spine and sacral wound with wound vacuum. R15 had an order for Norco 5/325 1 tablet orally daily before wound	F 309		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145734	A. BUILDING ______ B. WING ______	03/18/2015

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F 309	Continued From page 4	F 309		

care and it's specified to be given at 9 AM.

On 03/17/15 at 11:05 am, E9 (PT/Physical Therapist) and E10 (PT assistant) turned R15 after providing electrical stimulation therapy at 10 AM. While turning, R15 was observed moaning and grimacing. R15 stated, "It hurts!" E9 stated that most of R15's pain is in the hip when he is being turned. E9 notified the nurse of R15's pain. At 11:55 am, E7 (Nurse) was asked if R15 received pain medication. E7 nurse stated that she was about to give it because R15 was sleeping earlier.

R15's MAR did not show pain assessment in the record. There was no documentation on the effectiveness of the daily pain medication. The facility staff only documented Tylenol PRN that was given on 2/21/15 at 9 PM.
On 03/17/15 at 11:40 AM, E8 (CNA/Certified Nursing Assistant) stated that most of the time he takes care of R15 and R15 would yell and moan when he was turned every two hours and at other times. E8 stated R15 showed pain during repositioning. The only other pain medication ordered was Tylenol 650 mg orally every six hours as needed.

On 03/18/15 at 11:20 AM with E20 (Nurse) present, R15 was asked about his pain and effectiveness of the pain medication. R15 said he still had pain in the hip and his feet ached. At the same time R15 was observed grimacing and pointing to his right hip and his feet where the pain was. R15 stated that he got a little relief from the medication given in the morning.

R15's pain management Care Plan interventions included to:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145734	A. BUILDING ______ B. WING ______	03/18/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VILLA AT EVERGREEN PARK,THE	10124 SOUTH KEDZIE EVERGREEN PARK, IL 60805

(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 309	Continued From page 5	F 309		

" Anticipate the resident's need for pain relief and respond immediately to any complaint of pain. Evaluate the effectiveness of pain interventions (Specify Freq)": Frequency not specified.

The documentation of R15's pain management did not show regular monitoring of pain, effectiveness or ineffectiveness of treatment such as analgesics and immediately respond to R15' s complain of pain.

3. R17's admission record dated 12/18/14 showed R17 was admitted with diagnoses that included Aftercare for Traumatic Hip Fracture. R17's Minimum Data Set dated 12/25/14 assessed R17 cognitively as moderately impaired and required extensive assistance in all activities of daily living.

R17's Physician Order Sheet for February/ March 2115, showed an order for Acetaminophen 650 milligrams by mouth as needed for pain (prn) and an order for Hydrocodone 5-325 mg take 1 tablet by mouth every 4 hours as needed. These orders did not have a parameter pain scale for which analgesic to give R17 for her pain.

E21 (RN) was asked on 3/17/15 at 12:00 PM how does she determine what pain medication to give R17 when she is in pain. E21 stated "I can tell sometimes they way she moans."

R17's initial comprehensive pain assessment dated 12/18/14 was incomplete R17 was not assessed using a numerical pain scale from 1-10, R17 was not assessed for frequency of pain, and what made pain worse. Under possible conditions r/t pain is checked for pain due to hip fracture. Pain management includes Tylenol 650

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145734	A. BUILDING ______ B. WING ______	03/18/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VILLA AT EVERGREEN PARK,THE	10124 SOUTH KEDZIE EVERGREEN PARK, IL 60805

(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 309	Continued From page 6	F 309		

mg every 4 hours prn as needed and continue with current plan of care. There was no reassessment of R17's pain or that R17 was receiving Hydrocodone 10-325 mg in December on 12/24/14 through 12/31/14.

R17's Controlled Substance Form for the medication Hydrocodone/Acetaminophen 5-325 mg for the months of January, February and March 2015, showed R17 did receive the medication but there was inconsistent documentation on the prn medication form of the effectiveness of the medication and pain scale prior to administration and after.

R17's care plan for pain initiated on 12/18/14 included the following interventions:

Administer analgesia (specify medication) as per order. Give 1/2 hour before treatments or care.

Anticipate R17's need for pain relief and respond immediately to any complaint of pain.

Evaluate the effectiveness of pain interventions (every shift). Review for compliance, alleviating of symptoms, dosing schedules and resident satisfaction with results, impact on functional ability and impact on cognition.

Identify and record previous pain history and management of that pain and impact on function. Identify previous pain history and management of that pain. Identify previous response to analgesia including pain relief, side effects and impact on function.

The Facility Pain Assessment and Management

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145734	A. BUILDING ______ B. WING ______	03/18/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VILLA AT EVERGREEN PARK,THE	10124 SOUTH KEDZIE EVERGREEN PARK, IL 60805

(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 309	Continued From page 7	F 309		

Policy dated October 2010 under General Guidelines included:

1. The pain management program is based on a facility -wide commitment to resident comfort.

2."Pain management" is defined as the process of alleviating the resident's pain to a level that is acceptable to the resident and is based on his or her clinical condition and established treatment goals.

3. Pain management is a multidisciplinary care process that includes the following:

a. Assessing the potential for pain;
b. Effectively recognizing the presence of pain;
c. Identifying the characteristics of pain;
d. Addressing the underlying causes of pain;
e. Developing and implementing approaches to pain management;
f. Identifying and using specific strategies for different levels and sources of pain.
g. Monitoring for the effectiveness of the interventions; and
h. Modifying approaches as necessary.
4. According to the Physician Order Sheet (POS) R5 had diagnoses including Obesity, Hypertension, Dialysis. The POS showed R5 had a right chest permanent catheter with monitoring for edema every shift and the site dressing to be changed at dialysis center on dialysis days and as needed. The POS showed dialysis was using a new left atrio-ventricular fistula with interventions including to check for bruit/thrill every shift and document, to monitor for signs and symptoms of infection every shift and the site dressing to be changed at dialysis center on Mondays, Wednesdays and Fridays.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145734	A. BUILDING ______ B. WING ______	03/18/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VILLA AT EVERGREEN PARK,THE	10124 SOUTH KEDZIE EVERGREEN PARK, IL 60805

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F 309	Continued From page 8	F 309		

On 03/17/2015 at 11:50am E17 (Registered Nurse) with E2 (Director of Nursing) present, stated he was unsure which site was being used for dialysis. He said an assessment should be done when R5 returns from dialysis and it would be documented on the Medication Administration Record (MAR) or the Treatment Administration Record (TAR). Assessment documentation post dialysis could not be found on the MAR or TAR. R5 said a communication sheet post dialysis was sent from the dialysis center after each visit. Only two Dialysis Communication Records could be found in R5's medical record of the six times R5 had gone to dialysis.

On 03/17/2015 at 12:00pm R5 said the dialysis center was using his "port" site for dialysis and not the fistula site because the fistula was new and they hadn't started using it yet.

R5's dialysis care plan dated 03/04/2015 interventions included to check and change dressing daily at access site and document. The interventions also included to "monitor/document/report PRN any s/sx (signs and symptoms) of infection to access site: Redness, Swelling, warmth or drainage." The care plan did not indicate the location of the dialysis access site.

The facilities Dialysis access site Policy and Procedure dated 05/10 showed interventions for fistulas included a daily assessment to check the patency by feeling the access for a thrill and to listen with a stethoscope for a bruit.

5. R10 is a 65 year old resident that was admitted

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145734	A. BUILDING ______ B. WING ______	03/18/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VILLA AT EVERGREEN PARK,THE	10124 SOUTH KEDZIE EVERGREEN PARK, IL 60805

(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 309	Continued From page 9 11/21/14 with diagnoses that included end stage renal disease requiring hemodialysis, and atrial fibrillation with placement of a cardiac pacemaker. During initial record review the POS (physician order sheet) from admission showed only that R10 had had a pacemaker implanted on 11/14/14 to the Right chest and "Lf (left) forearm fistula for dialysis". Review of the subsequent POS shows no more detail for the pacemaker other than this. There was no detailed documentation as to the rate at which the pacemaker was set, the serial number, brand, or how often it should be checked. For the dialysis access site and dialysis treatment the POS only documents to monitor for infection symptoms and edema every shift. Dressing to be changed at dialysis and prn. The location of the access site is documented as: " Lt (left) hand (forearm) AV fistula" EMS dialysis clinic on Tue/Thur/Sat. Review of the nursing progress notes shows inconsistent documentation of the access site. For example : on 1/3/15 R10 is noted as going to dialysis. The next note is not until 1/8/15 and makes no reference to dialysis site. The first reference to the site is found in the nursing note of 1/21/15: "No s/s (signs and symptoms) of bleeding." The most recent note of 3/14/15 documents "Right arm fistula intact, no swelling or redness." The location of the site is not correct. The care plan prior to bringing it to the attention of the facility on 3/17/15 had no mention of the rate at which the pacemaker was set, the serial number, implantation date. The plan of care for hemodialysis does not contain information about monitoring for a bruit or thrill, what to do should the site bleed after	F 309		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145734	A. BUILDING ______ B. WING ______	03/18/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VILLA AT EVERGREEN PARK,THE	10124 SOUTH KEDZIE EVERGREEN PARK, IL 60805

(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 309	Continued From page 10 dialysis session or if trauma occurs.	F 309		
F 431 SS=E	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS 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.	F 431		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145734	A. BUILDING ______ B. WING ______	03/18/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VILLA AT EVERGREEN PARK,THE	10124 SOUTH KEDZIE EVERGREEN PARK, IL 60805

(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 11	F 431		

This REQUIREMENT is not met as evidenced by:
Based on observation, record review and staff interview, the facility failed to ensure that controlled substances were maintained under a double locked system, failed to follow procedure for disposal of residents medications, failed to maintain accurate records and documentation of the controlled medications.

This applies to 3 residents (R4, R17, R22) reviewed for controlled substances administration and documentation and 13 residents in the supplemental (R40, R41, R42, R43, R44, R45, R46, R49, R51, R52, R53, R54, R55) whose controlled substance medications were found stored in DON's (Director of Nursing) office, awaiting destruction, and with inconsistent documentation of receipt, of use, and of count accuracy.

The findings include:

On 3/18/15 at 1:30 PM, E2's (Director of Nursing/DON) was asked when and how controlled substances for discharged residents are disposed of. E2 stated that the disposal of the controlled substances is to be done with 2 RN's and is done when necessary. E2 was asked where the controlled substances for discharged residents were kept, E2 stated "in my office in a locked cabinet."

On 3/18/15 at 1:45 PM, in a locked drawer of E2's office dozens of bingo cards of oral controlled medications were found for multiple residents that had previously resided at the facility. There were also multiple bottles of liquid morphine, Fentanyl

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145734	A. BUILDING ______ B. WING ______	03/18/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VILLA AT EVERGREEN PARK,THE	10124 SOUTH KEDZIE EVERGREEN PARK, IL 60805

(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 12	F 431		

patches not labeled. Among these medications were examples of medications labeled for a particular resident but lacking a control sheet from the dispensing pharmacy, controlled medications with missing medications and matching control sheets with no reconciliation or count of medications dispensed. Among those residents, were medications that had been stored by the facility as far back as October 2014.

Over 73 controlled medications were found in the cabinet. Some of the specific examples found are:

1. R17's face sheet showed R17 was admitted to facility on 12/18/14 with diagnoses that included Aftercare For Healing Traumatic Fracture of Hip.

R17's record contained a prescription sent by hospital for Hydrocodone-acetaminophen (Norco) 10-325 milligrams (MG) po tablet, take 1 tablet by mouth two times daily for 30 days. Quantity **60 (Sixty) Tablet** Refills **0 (Zero).

Upon record review for R17, R17's pink "controlled substances proof of use sheet" for December 2014 was not in R17's record. E16 (nurse consultant) stated she found the pink control sheet in a box in the medical records office on 3/18/15. The control sheet showed the medication was delivered on 12/19/14 with 30 tablets. The control sheet reflected there were 9 tablets that were left as of 1/13/15. When E2 was asked where the bingo card for R17 Hydrocodone /Acetaminophen 10/325 mg was, She stated in the drawer in my office. E16 confirmed the control sheet and control medication card were not together. The December 2014 control sheet for R17 lacked a signature of who accepted the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145734	A. BUILDING ______ B. WING ______	03/18/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VILLA AT EVERGREEN PARK,THE	10124 SOUTH KEDZIE EVERGREEN PARK, IL 60805

(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 13 medication. A Fentanyl patch for R55 was found in E2's drawer. There was no control substance sheet attached to patch or how many patches were delivered. R55 was discharged on 1/16/15. A bingo card for R54's Methadone 5 mg tablets was found in E2's drawer with no control sheet of acceptance or administration. R54 was discharged on September 2014. A bottle of liquid morphine for R53 was found in E2's drawer with no control sheet when drug was delivered or administered. It was delivered on 3/9/15. Two bingo cards for R40 for Methadone 5 milligrams with 30 tablets on one card and 15 on another were delivered on 2/26/15 and signed for. The medication order was for 1 tablet by mouth every 8 hours. The control sheet for the Methadone 5 milligrams showed there were 39 tablets left on 2/28/15. The bingo cards showed there 6 tablets missing. R40 was discharged from facility on 3/6/15. R43's control sheet for Tramadol 50 mg shows the medication was signed out on 9/27/14 and as of 12/3/14, 4 tablets were left. The bingo card showed there were only 3 tablets left. R43 was discharged on 12/17/14. R41's control sheet for Oxycontin 10 milligrams showed 30 tablets were signed for on 2/22/15. The control sheets showed that there were 19 tablets left, however the bingo card showed there were actually 14 tablets remaining. R41 was discharged on 2/28/14.	F 431		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 431	Continued From page 14 R42's control sheet for Hydrocodone/Acetaminophen 10mg-325 mg showed 15 tablets were delivered and signed for on 11/20/14. On 11/22/14 the control form showed documentation the medication was sent home with patient. The bingo card was still at the facility and showed 5 tablets left. R42 was discharged on 11/22/14. R44's control sheet for R44 showed that 15 tablets of Hydromorphone 4 mg tablet was delivered on 12/21/14. The control substance form on 12/25/14 at 12:00 AM and 1:00 AM showed 2 tablets were wasted. There was no signature by two nurses that this medication was wasted. On 2/15/15 at 11:00 PM control substance sheet showed 6 tablets remaining but actually 7 tablets were left in the bingo card. R44 was discharged on 12/28/14. R45's controlled substance proof of use sheet showed Alprazolam 0.25 mg 15 tablets was delivered on 1/17/15. The control sheet dated 2/17/15 showed 10 tablets remained. The bingo card showed 8 tablets remaining. R45's discharge dated was 2/25/15. R46's controlled substance proof of use showed 15 tablets of Lorazepam 0.5 mg was delivered on 8/15/14. The resident was discharged on 9/13/14. R22's, R49's, R51's and R52's controlled substance proof of use lacked signatures of acceptance and disposal. The controlled substance proof of use form stated " the nurse who signs this record must also	F 431		

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F 431	Continued From page 15	F 431		

sign the separate medication administration record for each dose given. The form also states every dose must be accounted for on this form. If dose is contaminated, lost, broken, or refused enter the information under comments. The form also requires documentation of doses transferred to disposal record indicating quantity, dated, nurse signature and witness.

The consultant pharmacist summary provided by the facility for January 2015, February 2015, March 2015 showed under "Controlled Substances" d) controlled substances are destroyed in a timely manner, or per regulation as possible. Z1 (consulting pharmacist) stated on 3/18/15 at 1:00 PM, that she does not oversee the destruction of the controlled medications. Z1 stated she does ask the (E2) DON if the destruction of the controlled medications is being done and "I take her word on it."

Facility Policy for Discarding and Destroying Medications dated February 6, 2015 states "Medications that cannot be returned to the dispensing pharmacy (e.g., non unit dose-medications, medications refused by the resident, and / or medications left by resident shall be destroyed.

Under Policy Interpretation and Implementation states
1. All Controlled substances shall be retained in a securely locked area with restricted access until authorized individuals destroy them.

2. Non-controlled and Schedule V controlled drugs must be destroyed in the presences of two (2) licensed nurses.

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F 431	Continued From page 16	F 431		

3. Schedule II, III, and IV controlled drugs must be destroyed by the Director of Nursing Services or designee and another licensed nurse.

4. Ointments, creams and other like substances may be discarded into the trash receptacle in the medication room.

5. Whoever witnesses the destruction/disposal of medications must sign and dated the medication disposition record.

6. The medication disposition record must contain, at a minimum, the following information:

a. The resident's name;
b. Date medication destroyed;
c. The name and strength of the medication;
d. The prescription number (if any)
e. The quantity destroyed
f. Signature of witnesses

7. Completed medication disposition records shall be kept on filed in the facility for least two (2) years, or as mandated by state law governing the retention and storage of such records.

R4 has diagnoses that include Mild Mental Retardation, Closed Fracture of Ankle, Anemia and Hip joint replacement. R4 was readmitted on 2/28/15 after Hip revision.

February and March 2015 POS (Physician Order Sheet) showed that R4 had an order for Norco 5/325 mg (2 tablets) every 4 hour PRN (as needed) for pain and Tylenol 650 mg every 6 hour PRN for pain. These orders did not have

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F 431	Continued From page 17 parameters on when to use one or the other. Review of R4's Controlled Substances Proof of Use sheet showed that on 02/24/15 there were 15 tablets delivered to the facility. On this Controlled Substances Proof of Use sheet showed that E6 (Nurse) signed out 17 tablets of R4's Norco medication. E6 signed out the Norco medication on the following dates: 2/28 at 10 PM- 2 tablets, 3/1 at 9 AM- 2 tablets, 3/1 at 1 PM-2 tablets, 3/1 at 6 PM-1 tablet, 3/3 at 6 AM-2 tablets, 3/3 at 12 PM-2 tablets, 3/3 at 4 PM-2 tablets, 3/3 at 10 PM-2 tablets, and 3/5 at 10 AM-2 tablets. All these times and dates were signed by one nurse (E6). No comments were written on the comments section, no parameters documented and no follow up provided if pain medication were actually given. There were 17 tablets signed out but the medication container only held 15 tablets. R4's March 2015 MAR (Medication Administration Record) 2015 did not show that the medications for pain were given as there was no documentation in the MAR. On 03/17/15 at 12:40 PM E6 was asked about the medications signed out from R4's Norco medication bingo card. E6 acknowledged that she signed out all the medications from R4's bingo card. E6 did not sign on R4's MAR that these narcotic pain medication were given.	F 431		
F 465 SS=C	483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABL E ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public.	F 465		

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F 465	Continued From page 18	F 465		

This REQUIREMENT is not met as evidenced by:
Based on observation and interview the facility failed to ensure the resident environment was clean and free of debris. The facility failed to maintain the facility structure and resident environment in good repair.
This applies to all 151 residents in the facility.
The findings include:
General tour of the environment was done on 3/16/15 at 10:00am with E(14) Maintenance Director and E(15) Housekeeping Director.
On unit 100 in the dining/activity area Part of the floor board was missing and a metal corner plate was broken and sticking out with sharp edges. This is located on the outside of the nursing station making an unsafe passageway for residents while ambulating or pedaling in a wheelchair. On the wall in the dining room there was an area of missing plaster and the plaster is crumbled in pieces on the floor. Two pieces of bracket hardware were lying on the dining room window sill were covered with a thick black sticky substance. One of the resident tables was very wobbly and the top was loose. One resident table had a piece of wood missing off the corner of the table leaving sharp edges exposed to residents who sit at the table. A set of two water fountains off the side of gathering area had a large amount of brown and white build up in the basins of the drains. The wall under the fountains was splattered with a dark substance. The air vent under the fountains was covered with dust and debris and a dark brown substance was splattered on the grill.
The bathroom in the room that is shared by R26 and R27 was covered with a dark sticky

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F 465	Continued From page 19 substance. There was a loose power strip extension cord lying from one side of the room to the other on the side of R27 ' s bed. The heating unit in the room had a loose metal plate and the grill was covered with dust and debri. One handle on the bedside dresser was loose and hanging. The clean storage closet in the 100 unit showed multiple cases of supplemental drinks and formulas for tube feedings being stored on the floor. The floor was covered with dust and debris. R28's bathroom floor was covered with large areas of black and dusty debris. The toilet base is covered with a buildup of brown and black substance. The heating unit grill was filled with dust and debris. The soiled utility room floor was covered with a large amount of black sticky substance from the entry way to the middle of the room. The container holding the garbage was not covered. A mattress was lying on the floor. An air mattress was lying on top of a biohazard disposal container. The room had a very foul odor. The hopper in the room had a brown substance floating around and is stuck on the sides of the bowls. R29's and R30's bathroom door was cracked and the veneer was sticking out and leaving sharp edges sticking out. The tile in the bathroom was sticking up and was black in color. The base of the toilet was covered with a black buildup. There were two towels in front of the windows. E14 (Maintenance Director) stated, "They do that because they get cold and that helps keep the cold out." The floor of the room in general had areas of a black substance and debris under the beds and about the room. In rooms where R31, 32 and R33 resided had broken blinds by the bed leaving sharp edges. There was a bed side commode with the inside	F 465		

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F 465	Continued From page 20 bucket and lid being stored on the floor. There was a dark substance spotted on the bedside curtains and a dark substance splattered on the wall. There was a broken garbage can with sharp edges. In the bathroom bath by the shower there was a large missing area of tile that exposes the cement of the wall. The lighting was very dark. There were two lights with different colored covers. One of the covers was yellow making the light dim. The bathroom did not have a door. There was a curtain being used as the door and was loose at the top preventing or/making difficult the movement to close the curtain shut. The bathroom had a very foul odor. The heating unit side panel was on the floor. The clean storage closet on unit 200 had boxes of adult briefs, bed pans, isolation gowns, drinking cups, a case of citrate of magnesia, box of urinals and a bottle of stool softener being stored on the floor. The floor was covered with dust and debris. There were areas of a black substance on the floor. There was a pair of work gloves that had a black substance covering them lying on top of clean respiratory supplies. The sink in this room had a large amount of brown buildup with debris in the bottom of the bowl. The cabinets holding resident care supplies had a large amount of brown build up and splatter all over. The community shower in the 300 unit had only two lights out of eight that were working. The room was very dark. In R34's room the private refrigerator showed a buildup of frost. E15 (Housekeeping Director) stated it was the responsibility of housekeeping staff to make sure that the refrigerators are clean. R35's and R36's floor was dirty with debris in different areas. The bathroom had a large area of sticky black substance on the floor. R35	F 465		

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F 465	Continued From page 21 stated, "I am glad you're here. They never do it right. The floor is never cleaned right." R37 and R38 are both female residents in the 400 unit and share a bathroom. At 11:00am in the bathroom was a male urinal with urine in the bottom hanging on the hand bar next to the toilet. There was no name on the urinal. At 4:00pm rechecking the bathroom the urinal was still there with no name and a smaller amount of urine inside. There was a very strong odor of urine on both observations. In room R39's room the side of the heating unit was lying on the floor. The unit inside was full of dust and debris. During initial kitchen tour on 3/15/15 at 10 am it was observed that the dishwashing area of the kitchen was very dark making it difficult to see the area clearly. The ceiling contained light fixtures, some of which were lit and some that were not. It was noted that just inside the door to this area were three light switches. One was in an upward position and two were in a down position. The switches were flipped to see if this would produce more light in the area. This made no difference in the lighting. The two switches that were down produced no light when up and the the switch that was up caused the one light that was on to be extinguished. During this time it was observed that the dietary staff was trying to clean the area washing the walls with a hose and attempting to clean the area where the soiled plates are scraped. During the tour it was also noted the walk in freezer in the kitchen had a build up of ice on the ceiling area at the back of the freezer above the condenser. The ice build up had also dripped onto the floor area creating several small areas of ice build up on the floor. The freezer had storage shelves with product on it under the ice build up.	F 465		

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F 465	Continued From page 22 The CMS form titled "Resident Census and Condition dated 3/15/15 documented a census of 151 residents.	F 465		
F 514 SS=E	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to ensure resident medical records are complete and accurate in the area of medication administration and management and behavior monitoring. This applies to 6 resident medical records (R4,R11,R15,R17,R20, R24) reviewed for controlled substance documentation. The findings include:	F 514		

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F 514	Continued From page 23	F 514		

1. R17's face sheet showed R17 was admitted to the facility on 12/18/14 with diagnoses that included Aftercare For Healing Traumatic Fracture of Hip.

R17's record contained a prescription sent by hospital for Hydrocodone-acetaminophen (NORCO) 10-325 milligrams (MG) po tablet, take 1 tablet by mouth two times daily for 30 days. Quantity **60 (Sixty) Tablet** Refills **0 (Zero).

R17's Medication Administration Record and PRN Administration Record for January, February, March 2015, showed inconsistent documentation of when R17 received the medication and the effectiveness of the medication

The controlled substance proof of use form stated " the nurse who signs this record must also sign the separate medication administration record for each dose given. The form also states every dose must be accounted for on this form. If dose is contaminated, lost, broken, or refused enter the information under comments. The form also requires documentation of doses transferred to disposal record indicating quantity, dated, nurse signature and witness.

E16 (consultant) stated on 3/18/15 at 9:30AM, when nursing staff are giving controlled substances, the nurse must sign off on the "Controlled Substance Proof of use" (pink sheet) prior to administering the medication, and then sign off on the PRN medication information form (blue sheet) after administration. E16 further stated that if the controlled substance is a scheduled medication, the nurse would then sign off on the Medication Administration Record (MAR).

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F 514	Continued From page 24	F 514		

Facility Policy titled Documentation of Medication Administration states "The facility shall maintain a medication administration record to document all medications administered." Policy Interpretation and Implementation states:

1. Nurse shall document all medications administered to each resident on the resident's medication administration record (MAR).

2. Administration of medication must be documented immediately after (never before) it is given.

3. Documentation must include, as a minimum.

a. Name and strength of the drug.
b. Dosage;
c. Method of administration (e.g., oral, injection (and site), etc.);
d. Date and time of administration
e. Reason (s) why a medication withheld, not administered, or refused (as applicable); and
f. Signature and title of the person administering the medication.

2. R4 has diagnoses that include Mild Mental Retardation, Closed Fracture of Ankle, Anemia and Hip joint replacement. R4 was readmitted on 2/28/15 after Hip revision.

February and March 2015 POS (Physician Order Sheet) showed that R4 had an order for Norco 5/325 mg (2 tablets) every 4 hour PRN (as needed) for pain and Tylenol 650 mg every 6 hour PRN for pain.

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F 514	Continued From page 25 Review of R4's Controlled Substances Proof of Use sheet showed that E6 (Nurse) signed out 17 tablets of R4's Norco tablets. E6 signed out the Norco medication on the following dates: 2/28 at 10 PM- 2 tablets, 3/1 at 9 AM- 2 tablets, 3/1 at 1 PM-2 tablets, 3/1 at 6 PM-1 tablet, 3/3 at 6 AM-2 tablets, 3/3 at 12 PM-2 tablets, 3/3 at 4 PM-2 tablets, 3/3 at 10 PM-2 tablets, and 3/5 at 10 AM-2 tablets. All these times and dates were signed by one nurse (E6). No comments were written on the comments section, no parameters documented and no follow up provided if pain medication were actually given. There were 17 tablets signed out but the medication container only held 15 tablets. There was no documentation on R4's MAR dated March 2015 to show that the Norco was administered on the above mentioned. On 03/17/15 at 12:40 PM E6 was asked about the medications signed out from R4's Norco medication bingo card. E6 acknowledged that she signed out all the medications from R4. E6 did not sign on R4's MAR that these narcotic pain medication were given. 3. R15 has diagnoses including Right hip Fracture S/P Arthroplasty, both Lower Extremity DVT (Deep Vein Thrombosis), spine and sacral wound with wound vacuum. R15 has an order for Norco 5/325 1 tablet orally daily before wound care and it's specified to be given only at 9 AM. R15's Controlled Substance proof of use showed Extra Norco 5/325 mg tablets signed out on 02/27/15 at 2 PM and on 03/03/15 at 3 PM besides what were signed out at 9 AM. These	F 514		

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F 514	Continued From page 26 medications were not signed as given to R15's MAR sheet nor on the nurse's notes. Also Norco 5/325 mg was signed out on 3/5/15 at 9 AM and 3/14/15 at 9 AM. These medications were not signed or documented as given or omitted with no explanation. 4. R20 has an order for Norco 7.5-325, one or two tablets orally every 6 hours PRN (as needed). Review of Controlled Substances proof of use showed the following medications were signed out by facility staff on 11/26/14 at 2 PM 1 tablet, 11/27/14 at 7 AM 1 tablet, 12/21/14 9 AM 1 tablet, 12/22/14 at 9 AM 2 tablets, 12/24/14 at 9 AM 2 tablets, 01/27/15 9 PM 2 tablets, 02/02/15 at 4 PM 1 tablet and 3/8/15 at 2:15 PM 1 tablet. PRN (as needed) medication information on the Medication Administration Record (MAR) did not show that the above medications were signed as given to R20 and no explanation was provided. On 03/16/15 at 3:25 PM E19 (Nurse) said that if the PRN medication were given it has to be documented on the MAR PRN form and evaluated after giving the pain medication. 5. According to the Physician Order Sheet (POS) dated March 2015, R11 had diagnoses including Schizophrenia and Bipolar. The Brief Interview for Mental Status dated January 15, 2015 showed R11 was cognitively intact. The POS showed an order dated 12/09/14 for Lorazepam 0.5 milligrams (mg) every eight hours as needed for anxiety which was discontinued on 02/20/15. R11's POS also showed orders for antipsychotic medications Trifluoperazine 5 mg to be given	F 514		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145734	A. BUILDING ___ B. WING ___	03/18/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VILLA AT EVERGREEN PARK,THE	10124 SOUTH KEDZIE EVERGREEN PARK, IL 60805

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F 514	Continued From page 27 twice daily and Quetiapine Fumarate 100 mg to be given at bedtime. On 03/18/2015 at 6:10pm Z2 (Psychiatrist) stated he had discontinued R11's Lorazepam because it was never meant to be given as a long term medication since it can be addictive. He said given R11's diagnoses, she shouldn't be on Lorazepam for more than a couple of weeks. When Z2 evaluated R11 in February 2015 he determined she wasn't having any symptoms of anxiety to warrant continuing the order for Lorazepam and discontinued the medication. Z2 said the facility kept a behavior assessment form for each resident which he reviews during a visit to determine what behaviors the resident may be exhibiting. On 03/16/2015 at 12:30pm R11 said she was content in the facility and did not have any problems with pain or any medications. R11's Controlled Substances Proof of Use form showed Lorazepam 0.5 mg was signed out 15 times between 01/18/2015 and 02/17/2015. One tablet of Lorazepam 0.5 mg was signed out each time on the following dates: 1/18 at 9pm, 1/21 at 8pm, 1/26 at 12pm, 1/27 at 12pm, 1/27 at 8pm, 1/31 at 10pm, 2/1 at 9pm, 2/2 at 10pm, 2/9 at 12am, 2/10 at 1am, 2/13 at 1am, 2/13 at 10pm, 2/14 at 4pm, 2/15 at 5pm and 2/17 at 9pm. R11's Medication Administration Record (MAR) did not show any dates of Lorazepam being administered. R11's Behavior Monitoring Record for December 2014 or February 2015 were blank. The January 2015 Behavior Monitoring Record could not be found in R11's medical record.	F 514		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 514	Continued From page 28 A Consultation Report dated 02/11/2015 from Z1 (Pharmacist) showed recommendations for the facility interdisciplinary team included to ensure ongoing monitoring and documentation of specific target behaviors and non-pharmacological approaches. 6. R24 was reviewed as a closed record. R24 was a resident at the facility from 1/27/15 through 2/2/15. R24 was admitted to the facility for short term care for rehabilitation. The physician order sheet showed that the physician ordered Hydrocodone to be given every four hours if needed for pain. This order was written on 1/28/15. January's medication administration sheet showed that no doses were given. The as needed medication administration sheet for January showed two doses were given on 1/30/15. The February medication administration sheet does not show the Hydrocodone at all. The PRN (as needed) medication sheet showed there were no doses given. The Controlled Substance Proof of Use sheet showed that from 1/29/15 through 2/2/15 that 15 doses were removed from the medication card. The last two entries show that the hydrocodone was given to R24 after being discharged from the facility.	F 514		