STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145225	A. BUILDING _____ B. WING _____	11/07/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST JOHN HOSPITAL LTC UNIT	800 EAST CARPENTER, 11TH FLOOR SPRINGFIELD, IL 62702

(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	F 000		
F 425 SS=D	Annual Certification 483.60(a),(b) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH	F 425		

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 follow their policy for medication management for one of five residents (R7) reviewed for medication administration in the sample of 10.

Findings include;

On 11/5/13 at 11:30 AM, E4, Registered Nurse

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 425	Continued From page 1	F 425		

(RN) was administering medications to her residents. On the tray of the portable electronic medical record (EMR) device, E4 RN, had three large plastic cups with room numbers written on them. Two of the cups were filled with medications. One of the cups containing medications also contained an unidentified tablet which was open, had been cut in half, and was not in any labeled packaging. The nurse took the medications out of the cup and placed them on the tray of the portable EMR. When asked, E4 could not remember the name of the medication which was out of its' packaging and unlabeled. E4 went into R7's room to administer his medications. Once in the room, E4 realized that the medications from the cup did not belong to R7. E4 then stopped and went back to the hospital Automated Dispensing Cabinet (ADC) to retrieve the correct medications. At this time E4 stated, "I thought these were (R7's) medications, I pulled them earlier, but now I'm not sure, and the EMR does not document they have been given. (R7) had a student this morning but I don't think she gave him his medications, I'll have to find out."

The second cup held two medications for another resident. A Nicotine Patch and Ativan. E4 stated, " the resident had refused these medications earlier," and went back to the ADC to dispose of the medications. E4 returned the Nicotine Patch, to the ADC, but then decided to keep the ativan out in the cup because, " the resident is getting agitated and I pulled this out earlier, but he refused it, so I might try to get him to take it at noon." E4 placed the medication back in the plastic cup, and left the cup on the EMR device tray. E4 then stated, " I'm not sure what to do with these leftover medications, I'll have to go

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F 425	Continued From page 2 through them later to see which of my patients they belong to, but I have to start giving my 12 o'clock medications now." During an interview with E2 RN,Director of Nursing, and E3 Nurse Manager on 11/5/13 at 12:30 PM, E3 stated, "the hospital policy states medications are to be taken out of the (ADC) and immediately given to the resident. Medications have to be administered from the original container, they have to be scanned. That nurse was definitely not following hospital policy." Review of the Hospital Medication Management Policy dated, 12/13/11 documents under Section Three; letter d, "Medications are administered immediately upon removal from ADC." Under the same section area ii., #2 "Labeling occurs when any medication or solution is transferred from the original package to another container."	F 425		