STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	14E845	A. BUILDING _____ B. WING _____	C 09/11/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILSON CARE	**4544 NORTH HAZEL STREET CHICAGO, IL 60640**

(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 1584328/ IL79292- No deficiency 1584263/ IL79217- Refer to F281, F309 1584589/ IL79586- No deficiency 1584661/ IL79663- No deficiency 1584677/ IL79687- No deficiency	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 medication as order, document a medication was given and the reason why a medication was not given according to the facility's policy for two of three residents (R1, R2) reviewed for medication in a sample of four. Findings include: The facility policy, Administration of Drugs, undated documents in part that unless otherwise specified by the resident's attending physician, routine medications should be administered as scheduled. The nurse administering the medication must record such information on the resident's MAR (medication administration	F 281		

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

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F 281	Continued From page 1	F 281		

record) before administering the next resident's medication. The nurse administering the medications must initial the resident's MAR on the appropriate line and date for that specific day.

The facility policy, Medication Administration, dated 12/20/2013 documents in part that all medications must be administered to the resident in the manner and method prescribed by the physician. In the event that a medication cannot be given, the reason must be documented in the Nurses Medication Notes on the MAR or Progress Notes, and the time frame circled on the MAR.

On 9/2/15 at 2:10 pm R1 states that he Z2(Physician) ordered Trazodone to help him sleep. R1 also states he has not been given Trazodone at night for over two weeks, and cannot fall asleep until after 1:00am, and then does not sleep well without it.

On 9/3/15 at 11:00am R2 stated that he has requested Ativan numerous times for anxiety and the nurses tell me that they don't have it.

At the medication cart with E6 LPN (Licensed Practical Nurse) on 9/3/15 at 5:45pm and there was no Trazodone 100 mg tablets in the cart for R1 and no Ativan 1mg for R2. E6 stated at this time that she has given R1 Trazodone every evening she worked for the past two weeks. E6 also stated she gave the last tablet last night (9/2/15) and ordered a refill which would not be delivered until late evening 9/3/15. E6 stated that she could not explain the difference between the pharmacy records and the MAR (Medication

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F 281	Continued From page 2	F 281		

Administration Record).

On 9/3/15 at 1:30pm via phone Z1(Pharmacist) stated that they received a new prescription for Trazodone 100 mg. thirty tablets written by Z2 (Physician) for R1 on 7/21/15. We deliver the medications in the evening so R1 would have started the Trazodone on 7/22/15. The facility requested a refill on 8/8/15 but it was too soon and the insurance company denied the request. The facility never sent another refill request until 9/3/15 at 1:24pm. The facility has to call or fax refill requests to refill this medication. We have not sent Trazodone 100 mg for R1 since 7/21/15. If the medication was administered correctly the last dose would have been given on 8/21/15.

On 9/4/15 at 10:25am Z5 (Pharmacist) stated that they received the POS (Physician's Order Sheet) on 8/11/15 for Ativan 1 mg for R2, but Z2 (Physician) never signed the prescription. We faxed the facility and the physician the sign off sheet one time with no response. Z5 also stated it is the facility's responsibility to follow up on unsigned prescriptions. We never received the signed prescription.

On 9/3/15 at 2:30pm E2 DON (Director of Nursing) stated that the facility only uses one pharmacy and there is no house stock for Trazodone. E2 also stated that problems with medication should be reported to the DON. I was not aware of the problems and I cannot explain the difference between the pharmacy records and the MAR (Medication Administration Record) for R2. E2 also stated she unaware R1 had not received Trazodone as scheduled.

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F 281	Continued From page 3 On 9/4/15 at 10:10am Z2 (Physician) stated that he is at the facility every Tuesday and no one informed him there were problems with R1 and R2's medication. I also have not received any phone calls until 9/2/15 when I was informed R2's Ativan prescription had not been filled. R2 has anxiety and requires Ativan to help calm him down. R1 has insomnia, which is part of his mental illness, and Trazodone is given to help R1 sleep. The MAR (Medication Administration Record) documents that on 8/22, 8/24, 8/25, 8/26, 8/28, 8/29, 9/1, 9/2, E6 LPN administered Trazodone 100mg at 9:00pm. The MAR has no notation for 8/23 and 8/30 at 9:00pm for Trazodone 100 mg. The MAR documents that E5 LPN administered Trazodone 100mg 8/27, and 8/31 at 9:00pm. The MAR documented a "2" on 9/3/15 indicating a missed dose of Trazodone 100mg for R1. The POS (Physician's Order Sheet) documents that Ativan 1mg every four hours by mouth as needed was ordered Z2 by on 8/11/15 for R2. The MAR dated 8/10/15 through 9/9/15 documents that Ativan 1mg has never been administered to R2.	F 281		
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.	F 309		

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F 309	Continued From page 4	F 309		

This REQUIREMENT is not met as evidenced by:
Based on observation, interview and record review the facility failed to obtain and administer medications as ordered for the treatment of mood and sleep disorder for two of three residents (R1, R2) reviewed for medications, in a sample of four.

Findings include:

1. On 9/2/15 at 2:10 pm R1 stated that Z2 (Physician) ordered Trazodone to help him sleep. R1 also stated he has not been given Trazodone at night for over two weeks, and cannot fall asleep until after 1:00am, and then does not sleep well

On 9/3/15 at 1:30pm via phone Z1(Pharmacist) stated, they received a new prescription for Trazodone 100 mg. thirty tablets written by Z2 (Physician) for R1 on 7/21/15. We deliver the medications in the evening so R1 would have started the Trazodone on 7/22/15. The facility requested a refill on 8/8/15 but it was too soon and the insurance company denied the request. The facility sent another refill request on 9/3/15 at 1:24pm. The facility has to call or fax refill requests to refill this medication. We have not sent Trazodone 100 mg for R1 since 7/21/15. If the medication was administered correctly the last dose would have been given on 8/21/15.

The MAR (Medication Administration Record) documents that on 8/22, 8/24, 8/25, 8/26, 8/28, 8/29, 9/1, 9/2, E6 LPN administered Trazodone 100mg at 9:00pm. The MAR has no notation for 8/23 and 8/30 at 9:00pm for Trazodone 100 mg.

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F 309	Continued From page 5	F 309		

The MAR documents that E5 LPN administered Trazodone 100mg 8/27, and 8/31 at 9:00pm. The MAR documented a "2" on 9/3/15 indicating a missed dose of Trazodone 100mg for R1.

On 9/3/15 at 5:45pm while E6 LPN was present, the medication cart had no Trazodone 100 mg tablets in the cart for R1. E6 stated at this time that she has given R1 Trazodone every evening she worked for the past two weeks. E6 also stated she gave the last tablet last night (9/2/15) and ordered a refill which would not be delivered until late evening 9/3/15. E6 stated that she could not explain the difference between the pharmacy records and the MAR (Medication Administration Record).

On 9/4/15 at 10:10am via phone Z2 (Physician) stated he is at the facility every Tuesday and no one informed him there were problems with R1 and R2's medication. R1 has insomnia, which is part of his mental illness, and Trazodone is given to help R1 sleep.

Interview on 9/3/15 at 2:30pm E2 (DON/ Director of Nursing) stated that the facility only uses one pharmacy and there is no house stock for Trazadone. E2 also stated she was unaware R1 had not received Trazodone as scheduled.

The pharmacy's medication delivery sheet for R1 documents that Trazodone 100 mg, 30 tablets were delivered on 7/22/15 and the next delivery for Trazodone 100 mg, 30 tablets was 9/4/15.

2. On 9/3/15 at 11:00am R2 stated that he has requested Ativan numerous times for anxiety and the nurses tell me that they don't have it.

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F 309	Continued From page 6 On 9/3/15 at 5:45pm while E6 LPN was present, the medication cart had no Ativan 1mg for R2. The pharmacy's medication delivery sheet documents that the first delivery for lorazepam (Ativan) 1mg, 30 tablets was 9/5/15 for R2. On 9/4/15 at 10:25am via phone Z5 (Pharmacist) stated that they received the POS (Physician's Order Sheet) on 8/11/15 for Ativan 1 mg for R2, but Z2 (Physician) never signed the prescription. We faxed the facility and the physician the sign off sheet one time with no response. Z5 also stated it is the facility's responsibility to follow up on unsigned prescriptions. We never received the signed prescription. On 9/4/15 at 10:10am via phone Z2 (Physician) stated he is at the facility every Tuesday and no one informed him there were problems with R1 and R2's medication. I also have not received any phone calls until 9/2/15 when I was informed R2's Ativan prescription had not been filled. R2 has anxiety and requires Ativan to help calm him down. On 9/3/15 at 2:30pm E2 DON (Director of Nursing) also stated that problems with medication should be reported to the DON. She was not aware of the problems and she cannot explain the difference between the pharmacy records and the MAR (Medication Administration Record) for R2. The POS (Physician's Order Sheet) documents Ativan 1mg every four hours by mouth as needed was ordered by Z2 on 8/11/15 for R2.	F 309		

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F 309	Continued From page 7 The MAR dated 8/10/15 through 9/9/15 documents that Ativan 1mg has never been administered to R2. The facility policy, Administration of Drugs, undated documents in part that unless otherwise specified by the resident's attending physician, routine medications should be administered as scheduled. The nurse administering the medication must record such information on the resident's MAR before administering the next resident's medication. The nurse administering the medications must initial the resident's MAR on the appropriate line and date for that specific day.	F 309		