STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6001085	A. BUILDING _____ B. WING _____	03/13/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GREENTREE OF BRADLEY REHAB	650 NORTH KINZIE BRADLEY, IL 60915

(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) COMPLETE DATE
S 000	Initial Comments Licensure Follow Up Conditional to the survey of 10/24/18 The Greentree of Bradley Rehab failed to follow their Plan of Correction for the survey of 10/24/18 for 300.1610 a) 1).	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.1610 a) 1) Section 300.1610 Medication Policies and Procedure a) Development of Medication Policies 1) Every facility shall adopt written policies and procedures for properly and promptly obtaining, dispensing, administering, returning, and disposing of drugs and medications. These policies and procedures shall be consistent with the Act and this Part and shall be followed by the facility. These policies and procedures shall be in compliance with all applicable federal, State and local laws. This REQUIREMENT was not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure that resident medications were available for administration. This applies to 1 of 3 residents (R7) reviewed for medications in the sample of 8 and 1 resident	S9999	**Attachment A** **Statement of Licensure Violations**	

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(R107) in the supplemental sample.

The findings include:

1) On 3/12/19 at 10:42 AM, R7 was sitting in her wheelchair inside her room. R7 was alert and oriented x 3. R7 stated that she has lupus, fibromyalgia and back pains. Per R7, when she has pain, she would always ask for "Oxycodone" because she as an order to take it when needed. According to R7, "They run out of Oxycodone a couple of weeks ago. It took 2-3 days for them to get it. I recall that I didn't get it again for 2 days in a row a week ago prior to that." R7 stated that she was "so mad" that she called V2 (Director of Nursing) on the phone on 2/23/19 to let him know that she did not get the Oxycodone while she was in pain. R7 stated that she has an allergy to a certain Acetaminophen and is afraid to use Ibuprofen because it affects her kidneys. That is why she prefers to use "Oxycodone."

R7's face sheet showed multiple diagnoses which included, spinal stenosis lumbar region, fibromyalgia, rheumatoid arthritis, gout and systemic Lupus.

R7's POS (physician order sheet) showed an order for, "Oxycodone HCL (Hydrochloride) 5 mg (milligram), give 2 tablet by mouth every 4 hours as needed for pain."

R7's quarterly MDS (minimum data set) dated 1/27/19 showed that R7 is cognitively intact with a BIMS (Brief Interview of Mental Status) score of 15.

R7's current care plan for pain with the target date of 4/27/19, showed multiple interventions which included "Administer analgesia as per

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orders. Give ½ hour before treatments or care."

R7's MAR (medication administration record) for the month of February 2019 showed that the resident complained of pain on the night of 2/12/19 with a pain score of "4". R7 also complained of pain on 2/21/19 and 2/22/19 with a pain score of "6" on both nights. The same MAR also showed that R7 did not receive any of her as needed pain medication including the Oxycodone during the night shift on 2/12, 2/13, 2/21, 2/22 and 2/23/19.

R7's controlled drug receipt/record/disposition form showed that on 1/22/19, the facility received 30 tablets of Oxycodone 5 mg from the pharmacy. The 30 tablets was consumed on 2/11/19 at 7:00 PM per controlled drug receipt form. R7's controlled drug receipt/record/disposition form showed that on 2/14/19, the facility received 30 tablets of Oxycodone 5 mg from the pharmacy. The 30 tablets which was delivered on 2/14/19 was consumed on 2/21/19 at 12:00 noon per controlled drug receipt. R7's controlled drug receipt/record/disposition form showed that on 2/24/19, the facility received 30 tablets of Oxycodone 5 mg from the pharmacy. Based on the controlled drug records, R7's Oxycodone 5 mg was not available for the resident on 2/12, 2/13, 2/21 (after 12:00 noon), 2/22 and 2/23/19.

On 3/12/19 at 1:20 PM, V2 verified that he had got a call on his cell phone from R7 on 2/23/19 that she did not get her Oxycodone. V2 stated that he also got a call from nursing at 11:00 PM on 2/23/19 stating that they had run out of Oxycodone.

On 3/12/19 at 3:38 PM, V6 (Registered Nurse)

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stated that he has worked routinely with R7 and that she is alert and oriented. V6 stated that on the night shift, R7's pain scale is usually 4-7. V6 stated that R7 gets "Oxycodone prn (as needed) every 4 hours, 2 pills, total of 10 mg" for pain and there was a couple of times that it was not available.

On 3/12/19 at 3:43 PM, V5 (Pharmacist) stated that pharmacy received an order for Oxycodone on 2/13/19 and it was delivered on 2/14/19. V5 stated that the pharmacy also received an order for Oxycodone on 2/23/19 and it was delivered on 2/24/19.

2) On 3/11/19 at 4:20 PM, V5 (nurse) prepared and administered, multiple medications to R107 via gastrostomy tube. During the preparation of R107's medications, V5 stated that the resident's "Famotidine 20 mg" tablet is not available. Per V5, the facility has a new person in-charge of the house stock medication supplies and currently have not given the supply of the "Famotidine" medication. According to V5, because the "Famotidine" is not available, she cannot administer this medication to R107. V5 did not attempt to re-check the medication cart and there was also no attempt to check the facility emergency and/or convenience storage container.

R107's face sheet showed that the resident has a diagnosis of GERD (gastro-esophageal reflux disease).

R107's quarterly MDS dated 2/21/19 showed a BIMS (Brief Interview for Mental Status) score of "03" which meant that the resident is severely impaired with cognition. The same MDS showed

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that R107 required total assistance from the staff with most of her ADL (activities of daily living).

R107's active physician orders showed, "Famotidine Tablet 20 mg, give 1 tablet via G-Tube (gastrostomy tube) two times a day for heartburn." This medication order was made on 1/23/19.

R107's MAR dated 3/1/19 through 3/31/19 showed the resident's Famotidine medication is scheduled to be administered twice a day, every 6:00 AM and 5:00 PM. The same MAR showed "9" with V5's initial documented on 3/11/19 during the 5:00 PM scheduled administration. The MAR chart code for "9" meant "other/See Progress Notes."

R107's progress notes dated 3/11/19 (4:19 PM) showed documentation regarding order administration note for the Famotidine 20 mg medication, "On order."

R107's care plan related to the resident's diagnosis of GERD showed multiple interventions which included the administration of the ordered medication for heartburn.

The facility's policy and procedure regarding medication administration dated 2/19 showed, "All medications are administered safely and appropriately to aid residents to overcome illness, relieve and prevent symptoms and help in diagnosis." The same policy and procedure under the guidelines showed, "23. If medication is ordered but not present, check to see if it was misplaced and then call the pharmacy to obtain the medication. If available obtain from the emergency or convenience box."

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S9999	Continued From page 5 The facility's policy and procedure regarding medication administration schedule dated 11/2013 showed, "Medications shall be administered according to established schedules." The facility's policy and procedure regarding administering medications dated 11/2013 showed, "Medications shall be administered in a safe and timely manner, and as prescribed." (REPEAT B)	S9999		