STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ILL6003776	A. BUILDING: _____ B. WING _____	08/05/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRASMERE PLACE	4621 NORTH SHERIDAN ROAD 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) COMPLETE DATE
Z9999	FINDINGS Statement of Licensure Violations: Section 300.1630 Administration of Medication 300.1630 d) If, for any reason, a licensed prescriber's medication order cannot be followed, the licensed prescriber shall be notified as soon as is reasonable, depending upon the situation, and a notation made in the resident's record. This requirement is not met as evidenced by: Based on observation, interviews, and record review the facility failed to follow the facility's policies for filling missing medications and provide scheduled medication for 1 of 3 residents (R2) reviewed for medication administration in a sample of 4 residents. Findings include: On 7/21/15 at 11:30 AM during a tour of the facility, R2 (resident) stated "I have scoliosis and ankylosis and take Tylenol 3 tablets. The nurses tell me that my Tylenol 3's are empty and I have been waiting for them for two weeks." On 7/21/15 at 11:45 AM E2 (Director of Nursing) stated "Yes, we are waiting for our medication shipment. I believe R2 receives Tylenol 3s on an as need basis." On 7/22/15 at 1 PM a review was conducted of the Medication Administration Record (MAR). R2 was noted to have Tylenol 3 tablets given by mouth every 12 hours. The MAR noted 7/18/15 "Tylenol 3 missing, pharmacy called for refill." On 7/19/15 MAR noted "Tylenol 3 missing, pharmacy reported physician had not approved refill." On	Z9999	Attachment A Statement of Licensure Violations	

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Z9999	Continued From page 1	Z9999		

7/20/15 MAR noted "Tylenol to be sent on next delivery." Further investigation noted 5/3/15 MAR "Tylenol 3 out of stock, has been reordered." 5/4/15 "Tylenol 3 out of stock" and 5/6/15 MAR "Tylenol 3 has been reordered." On 5/10/15 and 5/11/15 MAR notes "Tylenol 3 out of stock, reordered, DON aware." Progress Notes did not have any notation of notifying the physician for further orders.

On 7/22/15 at 2 PM a review of the medication regimen was conducted using the Medication Administration Record (MAR). R2 was noted to be on "Cogentin, Pepcid, Vitamin B6, Haldol (PRN / as needed), and Risperdal injections monthly." Both R2 and R3 stated "there was one time though that I needed my as needed medication and the nurses told me that I was out and needed to get a refill."

On 7/22/15 at 10 AM Resident Council Meeting Minutes noted "Medications are not being delivered on time. Reply: Medication are to be dispensed as ordered by the physician. In the case of recent admission or changes in orders or medicaid prior authorizations issues, medication may not be immediately available. We are working hard reducing delays with lab and pharmacy."

On 7/22/15 at 2 PM E2 (Director of Nursing) stated "We have had a problem getting refills for our narcotic medications. There have been times where there is a delay in refills."

On 7/23/15 at 3 PM E1 stated "We have changed pharmacies and are in a period of change."

On 7/23/15 at 1:50 PM Z4 (Pharmacist) stated "We did not receive a request for R2's Tylenol 3s

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Z9999	Continued From page 2 till 7/21/15 at 2PM and was delivered the morning of 7/22/15." On 7/22/15 at 3 PM E2 (Director of Nursing) provided facility Medication and Treatment Policy (dated February 2014). The policy notes "Upon discover that the facility has an inadequate supply of medication to administer to a resident, the facility should initiate action to obtain the medication from the providing pharmacy.,,,3) If the medication shortage is discovered after normal pharmacy hours: a) a nurse should call the pharmacy's emergency answering service and leave a message. b) If the medication is unavailable from pharmacy, the facility should contact the attending physician/prescriber to obtain orders or directions. c) If the medication is unavailable from Pharmacy due to it being a controlled substance on the DEA (Drug Enforcement Agency) formulary, the facility should collaborate with the pharmacy and physician presecriber to obtain the proper elements of the prescription or determine a suitable therapeutic alternative. d) When a missed dose is unavoidable the facility should document the missed dose and the explanation for the missed dose on the Medication Administration Record or Treatment Administration Record." (C)	Z9999		