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S 000	Initial Comments Facility Reported Incident (FRI) of 2/21/21 - IL131419	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.1210b) 300.1210d)2) 300.3240a) Section 300.610 Resident Care Policies a) The facility shall have written policies and procedures governing all services provided by the facility. The written policies and procedures shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee, and representatives of nursing and other services in the facility. The policies shall comply with the Act and this Part. The written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, documented by written, signed and dated minutes of the meeting. Section 300.1210 General Requirements for Nursing and Personal Care b) The facility shall provide the necessary care	S9999	Attachment A Statement of Licensure Violations	

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and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive resident care plan. Adequate and properly supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident.
d)Pursuant to subsection (a), general nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour, seven-day-a-week basis:
2) All treatments and procedures shall be administered as ordered by the physician.

Section 300.3240 Abuse and Neglect

a)An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. (Section 2-107 of the Act)

These Requirements were not met evidenced by:

Based on observation, interview, and record review, the facility failed to suspend a nurse after an allegation of missing narcotic medication and an allegation that a nurse was not passing medications during her shift. The facility also failed to thoroughly investigate an allegation of missing narcotics and neglect. This applies to all residents in the facility. The facility neglected to ensure residents received physician prescribed medications as ordered from 8:00 AM 02/21/21 to approximately 02/22/21. This failure resulted in R2 experiencing pain without pain relief. The

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facility also failed to prevent verbal abuse of a resident. This applies to 2 of 9 residents (R2, R8) reviewed for abuse in the sample of 9. Also, R2 's February 2021 Physicain Order Sheet (POS) showed an order for Pregabalin (Lyrica) 150 milligram capsule; take one capsule by mouth two times daily at 8:00 AM and 5:00 PM. The POS showed an order for Pregabalin 100 milligram capsule; take one capsule daily at noon. R2 ' s POS showed and order for Hydrocodone-Acetaminophen (Norco) 10-325 milligram tablet; take 1 to 2 tablets by mouth every 4 hours as needed for pain.

The findings include:

The Facility Data sheet on 03/03/21 showed the resident census was 23.

The facility's Final Report dated 03/01/21 showed, "On 02/21/21, during shift change, performing narcotic count, four Xanax (a schedule IV controlled substance primarily used to treat anxiety and secondarily prescribed for insomnia) were missing for (R1) medication card. On 02/22/21 (V6 Registered Nurse) that was responsible for the Xanax (also known as alprazolam) stated as she punched Xanax out of medication card the four Xanax broke, and crumbled. She said she wasted them by throwing them away and did not have another nurse to verify that she wasted the four pills."

The facility's Rejected Punch Report showed that V6 started her shift on 02/21/21 at 4:24 AM.

The facility 's Hours Worked Simplified Report showed V9 Certified Nursing Assistant (CNA)

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worked on: 02/21/21 from 6:00 AM to 6:00 PM. The report showed, V8 CNA worked on 02/21/21 from 2:00 PM to 10:15 PM. The report showed, V11 CNA worked on 02/21/21 at 6:00 PM to 6:00 AM on 02/22/21 AM. The report showed, V10 CNA worked on 2/21/21 at 10:00 PM to 6:00 AM on 02/22/21. The report showed V5 Registered Nurse (RN) was V6's relief and worked from 02/21/21 at 6:00 PM to 02/22/21 at 6:00 AM.

1. R2 ' s Minimum Data Set from 01/26/21 showed he was cognitively intact with a Brief Interview for Mental Status score of 15 out of 15.

On 11:50 AM at 03/03/21, V1 Administrator stated V6 had only worked at the facility for three days. V6 said she approved V6 coming in early for her shift on 02/21/21 to familiarize herself with the facility.

On 03/3/21 at 12:03 PM, V2 Director of Nursing (DON) stated V6 was scheduled to work on 02/21/21 from 6:00 AM to 6:00 PM. V2 said, V6 was the only nurse in the building when the Xanax incident occurred. V2 said opioids and benzodiazepines (Xanax is classified as a benzodiazepine) are more likely to be diverted.

On 03/03/21 at 1:50 PM, V4 Licensed Practical Nurse (LPN) stated, "I have never had this (R1's Xanax) crumble before. (V4 presented R1's Xanax. R1's Xanax was a in a bubble pack dispensing card. The medication was a full tablet and appeared to have a peach colored coating. The medications was slightly smaller than a tic tac mint.) V4 said, "If it did crumble, I would get the DON (Director of Nursing) and waste it with her. If I was the only nurse on duty, I would save

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it and waste it with the next nurse. I would not dispose of the Xanax or Norco on my own that is nursing 101" V4 said at shift change on the morning of 02/22/21, "(V5) said we have a problem. He said we have to do a count together. There was a lot of missing Xanax and there was some Norco missing too." V4 said she was there to "shadow" and "watch" V6. V4 stated V6 had given her a medication cup with R2 's morning medications. V4 said when she approached R2 he had said he wanted two Norco. V4 said she knew there was Tylenol in the cup and not Norco. V4 said she went to V6 and told her R2 wanted two Norco and V6 said, "well, I gave those to you". V4 said she told V6 they were Tylenol, then V6 dispensed two Norco for R2." V4 said, "She (V6) was very out of it she wasn' t making any sense. I would ask her a question and she would have a blank look and say what?" V4 said, "Then at noon on 02/22/21 she popped out (R3' s) Norco and put it in a med cup on the med cart. (V6) was at the med cart and I was standing to her right. So on the med cart were two medicine cups; one with (R2 's) Lyrica (Schedule V controlled substance, Nerve pain medication) the other with (R3's) Norco. She (V6) went to grab the Lyrica and I said No put that back. Then she grabbed the Norco med cup with her left hand and took it behind her back. I told her to put the cup back. The cup she put back did not have the Norco in it anymore. It was some other medication. I told her no put the Norco back, I can see it in your left hand. I could see it in her hand. She (V6) was like Oh that is so crazy how my Excedrin (migraine medication) got in the medicine cup. I told her I didn' t know what that medicine was. If I passed that (medication) to the resident, I could have hurt him. (V6) knew exactly what she was doing; she was trying to steal (R2 's) Norco. I took the

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Excedrin and Norco to the Administrator and DON (Director of Nursing) and they pulled (V6) into her office. She (V6) was stealing the Norco, absolutely, I would testify to that. I think she stole the Xanax also. I think she stole the meds, took them, and it knocked her out and that 's why she slept here."

On 03/03/21 at 2:39 PM, V11 CNA V6 was standing in front of R1's room popping medications out of a medication card and into a cup. V11 said an hour after she witnessed this, R1 was asking for her medications. V11 said V6 was "not making sense, had slurred speech, and could not maintain her balance". V11 said V6 appeared to be under the influence. V11 said, "Also (R2 and R4) said they didn't get their pills. They said they hadn' t gotten any pills since their morning pills. That is the first I have ever heard those residents say that they have not gotten their medications before. They have never said that. They are all alert, and oriented enough to know if they had gotten their meds."

On 3/3/21 at 2:39 PM, V11 CNA said " ...Then (R8) came out and asked for her meds then (V6) yelled at her and cussed at her. I 've never heard a nurse yell at her like that. I ' ve never seen a nurse act like this before."

On 03/4/21 at 10:03 AM, R2 stated he recalled 02/21/21. R2 stated his roommate gets medications at 5:00 AM but he gets his at 7:00 AM. R2 stated he did not get any medications the entire day. R2 said, "I was having pain that day and some of the medication I wanted was my Norco pain medication. She never gave me my Norco or Tylenol ...If I had gotten my pain medication like I wanted it would have relieved my pain.

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On 03/04/21 at 12:20 PM, V2 stated she could not find R2 ' s missing Lyrica count sheet

On 03/04/21 at 3:40 PM, V5 Registered Nurse (RN) stated he had worked at the facility for 1.5 years. V5 said he was scheduled to work on 02/21/21 for a 12 hour shift starting at 6:00 PM. V5 said at approximately 5:00 PM on 02/21/21 he received a text message from V8 Certified Nursing Assistant (CNA), stating V6 did not appear to be "okay" and she appeared to be "under the influence." V5 stated when he arrived at the facility he approached V6 and she had resident Medication Administration Records and the controlled substance sheets out of their binders and spread over her cart. V5 said pulling the paper work out of the binder is not normal behavior. V5 said V6 "could barely stand. She could barely keep her balance and she could barely keep her eyes open." V5 stated R8 approached V6 and told V6 that "she (R8) never received her noon or supper time pills. (V6) told her she had given her the pills. She (V6) told her (R8) she is the nurse and she knows how to do her job. (R8) can be forgetful but not with her medications. (R8) has never made that accusation before so that was a red flag to me." V5 said V8 told him residents had been complaining all day about not getting their medications. V5 stated he asked the two most alert, and oriented residents (R2, R4) if they had received their medications during the day and they stated they had not received them. V5 stated he notified V2 Director of Nursing (DON) at approximately 6:39 PM on 02/21/21 that residents had stated they were not receiving their medications and V6 appeared to be under the influence. V5 stated "he did a narcotic count with

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V6 and there were several controlled substance cards missing as well as individual tablets of medications". V5 stated he notified V2 again, at approximately 7:00 PM. "I explained to her what was going on; that the count was off, and we had recounted several times. I told her she had to come in. She didn't have a choice, it was a narcotic discrepancy. I told her I did not take the keys (keys for controlled substance lock box). I told her I would leave if she didn't come in." V5 stated, at this point in time, V6 appeared "even more out of it." V5 stated he had called V1 "Administrator twice, shortly after he called V2, and notified her that V6 appeared to be under the influence and the controlled substance count was incorrect". V5 said when V1 and V2 arrived at the facility (exact time not known) the missing controlled substance medication cards were found however the individual tablets of medication were not found. V5 said, When (V1 arrived at the facility) she woke her (V6) up at the nurse's station, it was hard to wake her up. You could tell she was still under the influence. When she came to, she looked at us like what is going on and said "What?" (V1) said to "go lay down, so she did stay the night." V5 said, V6 would talk but her speech was nonsensical, "it was just words coming out of her mouth." V5 said he was not given direction in regards to V6 when she woke up. V5 said he was expecting an agency nurse to arrive in the morning for his relief. V5 said, "So then at 6:00 AM, (V6) comes out to nurse's station. She was wide awake, energetic, and she said lets count so you can go home. I said (V4 Licensed Practical Nurse) is the nurse; I'm not sure if (V4) is going to watch you or what." V5 said when V4 arrived he gave her report and V6 was present. V5 said, "When I was getting my things ready (to leave), I heard (V6) say I can take over, and (V4) said are you supposed to be

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doing med pass and me watching (V6) said "No I got it I can do it". In hindsight, (V2) should have come in at 5:00 PM when the CNA had called her and told her something was not right with the nurse. At that point she (V2) should have come in to check in on her (V6) with her being a new employee. If the migraine is so bad that you cannot pass medications, then you should not be working, I should have been given direction on what to do with (V6), I think they should have made her go home in the first place. She was not safe to be in the facility, it could have happened again."
is registered to pass meds, and I know you do not leave those medications laying out."

On 03/05/21 at 11:55 AM, V4 said when she had approached R2 on 02/22/21 with the cup of medications that contained the two Tylenol, V6 thought she had already passed them to R2. V4 said, "Then I became suspicious when she said you already gave that to (R2). I said, you mean you gave it to him earlier, and she (V6) said No you just gave it to him." V4 stated she went to the controlled substance record and V6 had signed out one Norco for R2. V4 said, Norco had not been given to R2 and was not in the medicine cup. V4 said V6 dispensed two Norco and V4 gave them to R2. V4 said the 1 Norco was unaccounted for. V4 said V6 had the keys to the controlled substances and there were times when V6 was not supervised. V4 said, "Then when I heard about the Xanax I asked (V6) what happened and she said I don't know. I said well did the (Xanax) break, she said oh yeah that is what happened and I was like why did I say that and put that excuse in her head." V4 said, "I was just watching her (V6) for training. No one told me to watch her. If I had known what had transpired the night before, I would have said she

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should not be working. I don't think she should been in the building. Personally I would have sent her home immediately."

On 3/5/21 at 2:18 PM, V10 CNA stated she heard V6 say to R8 "shut the fuck up." V10 was uncertain of the date this occurred. V10 said, "I remember (V6) was cussing at (R8), but (R8) cusses all the time and we just brush it off."

On 03/05/21 at 2:34 PM, V9 Certified Nursing Assistant (CNA) stated," She (V6) was acting like she was on drugs, (V6) was standing there and holding on to the counter, she was swaying and holding on to the counter. She was acting like she was on something. I've seen people on drugs and she was definitely on something; I just don't know what." V9 stated residents were complaining that they were not receiving their medication during the day on 02/21/21. V9 said she sent V2 a text message at 3:18 PM on 2/21/21 stating, "(V2) I think the new nurse is on something she 's acting completely different from this morning and almost falling asleep standing up. I know she is under a lot of pressure because she is by herself but I really feel she is on something. I don't know how to address the situation. (V8) is here with me and she said she seems off. I don ' t know if you could just pop in and say you were in the area to check on her." V9 said V2 sent her a reply message that V2 had called V6 and V6 said she had a migraine and vertigo and that V6 felt better. V9 said, "I did not think she had a migraine or vertigo." V9 said, during her shift she was approached by V6 and "she (V6) told me she made something that they give to psych (psychiatric) patients. She (V6) made it and it was in a syringe. (V6) asked who else she should give it to? Who else is being

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obnoxious?" V9 said she did not witness V6 pass any medications during her shift. V9 said, "She was not at all safe to be there working as a nurse. She (V6) was not safe, She could have really hurt a resident, pass the wrong meds or something like that. She should have been sent home and she definitely should not have worked the next day that is obvious; she was not safe to be around residents."

On 03/05/21 at 2:52 PM, V8 CNA stated she worked from 2:00 PM to 10:15 PM on 02/21/21. V8 said, "It was a pretty rough day." V8 said, "I asked three to four residents when they had last gotten their medication and they said in the morning. I hadn' t seen her (V6) leave the med cart at the nurse's station. I texted him around 4:45 PM. I texted him (V5) that I'm worried she is not passing meds all day and can you come in early and take care of this." V8 said, "(V6) was just standing there acting like she was passing meds but she wasn't. She had papers everywhere. (R8) was very upset that she did not get her meds. (R8) came up to (V6) and (R8) wanted her medications. (V6) was cussing at (R8), she was yelling at her. She said you already got your medications. Then she said you'll get your meds when you get your meds." (V6) was just parked there with the med drawers open, and not passing medications. There were a lot of lights (call lights) going off about the medications. (R1) put her light on and she wanted her meds. She will not go to bed until she gets her meds. (R2, R1, R8, R3) all had their lights on that they had not gotten there meds. Then (V2) came in around 9:30 PM; I think, it ' s hard to remember the exact time. (V6) was supposed to leave at 6:00 PM but she didn't have a ride so she was asking if she could sleep their (at the facility) because she had to work the next

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day. I was uncomfortable with that, she should not have been allowed to stay overnight she should have been sent home immediately and she definitely should not have been allowed to work the next day. She (V6) was putting the residents in danger, she could have passed the wrong medication and killed someone. (V9) agreed with me that she was under the influence. I do think she was under the influence of drugs. It would have been obvious to anyone that saw her that she was under the influence; it was obvious to us. She should have been sent home and the cops should have been called. Lives are on the line, someone could have died with that concoction she had made.

On 03/05/21 at 4:00 PM, V5 stated, in regards to the syringe left out, "I'm pretty sure it was morphine. The morphine was in a syringe and it looked like a full dose .25 ml (milliliters). I know it was morphine because the liquid morphine comes with its own syringe, and that was the syringe that was laying out. (V6) said it was for (R9) but she had forgotten to give it." V5 said the morphine was for R9, it had not been signed out, and R9 denied having pain.

On 3/9/21 at 9:52 AM, V2 Director of Nursing stated, "On 02/21/21 I don' t recall who first contacted me, I just know that (V5) contacted me that the narcotic count was off. (V9 CNA) sent me a message but (V6) said she was having a severe migraine with vertigo. She sounded fine on the phone when I talked to her." V2 said it is rare for staff to accuse another staff member of being under the influence and she has never received a message like that before. V2 said, "I got here at 8:30 PM on 02/21/21. (V5) said he thought she was under the influence. I thought she was sleepy." V2 said V6 was not questioned

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about the missing Norco until 02/22/21 and she is not certain if she was aware, on 02/21/21, of any other missing medications (besides the Xanax). V2 said, "I had not heard that residents were not getting their medications, you telling me this is now the first time I have heard this."

On 03/09/21 at 11:30 AM, V1 Administrator stated if there are missing narcotics or benzodiazepine we should suspend the suspected individual and do an investigation. V1 said, while pointing at the Controlled Substance tracking sheet, if I had known about these I would have sent her home. V1 said she did not interview the CNA ' s on duty and "I should have talked to the CNA ' s." V1 said, "If a CNA would report a staff member was under the influence, (V2) and I would communicate between each other, and one of us would come in. I would expect the staff to call me immediately. The nurse should be suspended and (V2) would take her place."

On 03/09/21 at 11:30 AM, V1 said, in regards to R1's missing Norco sheet, there is one missing dose of Norco given the frequency at which R1 receives her Norco and the number of doses in the Norco medication card.(R1 should have only been given 29 doses of Norco; however, the medication card contained 30. Facility remained unable to provide R1 ' s missing Norco count log.)

On 03/09/21 at 12:03 PM, V3 Medical Director stated, "A nurse who had taken Norco or benzo (Benzodiazepine, Xanax) you would see somnolence (sleepiness) that is the big thing. They would also have impaired judgement and not be able to stay on track. We use Xanax for sleep, and anxiety so you would see those side effects. Those medications are 100 percent at risk of being diverted. It 's peculiar I have not

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heard about this. I would hope to be notified if medications had gone missing or medications had not been given. I would hope someone call me about it, it is a big deal. (Relayed CNA statements regarding V6 ' s behavior: slurred speech, sleepiness, inability to stand upright without swaying) It sounds like she was impaired that is not a safe situation and the safest bet would be to send her home."

On 03/03/21 at 12:03 PM, V2 stated the medications belong to the resident 's and are their property.

R1's February 2021 Physician Order Sheet (POS) showed an order for Alprazolam (Xanax) 0.5 milligram tablets; 1 tablet three times daily. The POS also showed an order for Hydrocodone-Acetaminophen (Norco) 5-325 milligram tablets; 1 tablet three times daily.

R1 ' s Xanax Controlled Substance Proof of Use log showed that 4 Xanax (only ordered three times daily) had been signed out and on 02/22/21 4 Xanax were unaccounted for.

On 03/04/21 at 12:20 PM, V2 DON stated she was unable to find R1 ' s third Norco Controlled Substances Proof of Use log for the date of 02/22/21.

R2 's February 2021 POS showed an order for Pregabalin (Lyrica) 150 milligram capsule; take one capsule by mouth two times daily at 8:00 AM and 5:00 PM. The POS showed an order for Pregabalin 100 milligram capsule; take one capsule daily at noon. R2 ' s POS showed and order for Hydrocodone-Acetaminophen (Norco) 10-325 milligram tablet; take 1 to 2 tablets by mouth every 4 hours as needed for pain.

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S9999	Continued From page 14 R2 ' s Controlled Substance Proof of Use sheet for Pregabalin (Lyrica) 150 milligram two times daily showed no doses of Lyrica were signed out on 02/21/21 and the morning dose on 02/22/21 was not signed out. The Lyrica count sheet showed no count correction errors. (3 doses of Lyrica not signed out). R2 's Controlled Substance Proof of Use log for his noon dose of Pregabalin 100 milligram was requested for the date of 02/21/21. The log was not provided. R2 's February Medication Administration Record showed R2 ' s Pregabalin 150 milligram dose was initialed as given by V15 at 8:00 AM and 5:00 PM. (V15 was not in facility at 5:00 PM, and controlled substance count sheet showed no doses signed out for 8:00 AM or 5:00 PM.) R2 ' s February 2021 MAR for Tizanidine (muscle relaxant) 4 milligrams showed the 02/21/21 5:00 PM dose was initialed as given by V15 when V15 was not in the facility. R2 ' s Midnight dose was not initialed as being given. R2 ' s February 2021 MAR showed his 02/21/21 Midnight Hydroxyurea (Sickle Cell Anemia medication) was NOT initialed as being given. R5 's February 2021 Physician Order Sheet showed and order for Alprazolam (Xanax) 0.25 milligrams three times a day as needed for anxiety. R5 ' s Xanax Controlled Substances Proof of Use log showed on 2/21/21 2 missing Xanax in addition to more than the three prescribed doses were signed out.	S9999		

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R3's Physician Order Sheet showed an order for Hydrocodone-Acetaminophen (Norco) 5-325 milligrams 1 tablet by mouth every 8 hours as needed for pain. The order was started on 1/9/21.

R3 ' s Norco controlled Substances Proof of Use log showed R3 received two Norco cards on 02/16/21 with thirty tablets in each card. The first card was started on 02/20/21 at 3:45 PM. The log showed on 02/21/21 three doses were given. The first dose was given at 6:45 AM by V6, the second at 1:30 PM (no signature) the next two lines have three large black marker lines with error written next to them. The third dose on 02/21/21 was given at 11:15 PM by V5.

R3 ' s second Norco controlled substance log showed on 02/22/21 there were 3 unaccounted for norco.

R6 's February 2021 Physician Order Sheet showed, Morphine Sulfate 15 milligram tablets. Take 15 milligrams by mouth three times daily at 8:00 AM, 12:00 PM, and 5:00 PM.

R6 ' s Morphine Controlled Substance Proof of Use log showed on 02/22/21
(no time given) showed the expected count was 11 morphine tablets; however, the actual count was 10 tablets. (1 tablet of morphine unaccounted for.)

The facility ' s policy Controlled Substances reviewed on 11/6/18 showed, "If a resident refuses a dose of a controlled drug, or it is not given for any reason, the medication dose must be destroyed. The dose must be destroyed in the

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S9999	Continued From page 16 presence of two Licensed Nurses and documented on the disposition sheet as destroyed." The facility ' s Abuse Prevention Program Policy revised on 11/28/16 showed, "This facility is committed to protecting our residents from abuse by anyone including; but not limited to, facility staff ..." The policy defines Misappropriation of Resident property means the deliberate misplacement, exploitation, or wrongful, temporary, or permanent use of a resident ' s belongings or money without the resident ' s consent." The policy showed, "Employees are required to immediately report any occurrences of potential/alleged mistreatment, exploitation, neglect and abuse of residents and misappropriation of resident property they observe, her about, or suspect to a supervisor and the administrator." The policy continued, "The facility will take steps to prevent mistreatment, exploitation, neglect, and abuse of residents and misappropriation of resident property while the investigation is underway ...Employees of the this facility who have been accused of mistreatment, exploitation, neglect, abuse or misappropriation of resident property will be immediately removed from resident contact until the results of the investigation, have been reviewed by the administrator or designee. Employees accused of alleged mistreatment, exploitation, neglect, abuse or misappropriation of resident property shall not complete their shift as a direct care provider to residents." The facility ' s Abuse Prevention Program Policy revised on 11/28/16 showed, "This facility is committed to protecting our residents from abuse by anyone including; but not limited to, facility staff." The policy defines "Verbal Abuse is the	S9999		

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S9999	Continued From page 17 use of oral, written, or gestured language that willfully includes disparaging and derogatory terms to residents or families, or within their hearing distance regardless of their age, ability to comprehend, or disability. Example of verbal abuse include, but are not limited to, threats of harm, or saying things to frighten a resident." " B "	S9999		