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S 000	Initial Comments Complaint Investigation: 2510430/IL184700	S 000		
S9999	Final Observations Statement of Licensure Violations: 330.710a) 330.785b)4) 330.4210a)1)2)B-No Violation will be issued for this Code 330.4210g) Section 330.710 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 with the involvement of the administrator. The written policies shall be followed in operating the facility and shall be reviewed at least annually by the Administrator. The policies shall comply with the Act and this Part. Section 330.785 Contacting Local Law Enforcement b) The facility shall immediately contact local law enforcement authorities (e.g., telephoning 911 where available) in the following situations: 4) When a crime has been committed in a facility by a person other than a resident; Section 330.4210 General a) No resident shall be deprived of any rights, benefits, or privileges guaranteed by State or federal law based on their status as a resident of a facility. 1)Residents shall have the right to be treated with courtesy and respect by employees or persons providing medical services or care and	S9999		

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shall have their human and civil rights maintained in all aspects of medical care as defined in the State Operations Manual for Long-Term Care Facilities.

2)Residents shall have their basic human needs, including but not limited to water, food, medication, toileting, and personal hygiene, accommodated in a timely manner, as defined by the person and agreed upon by the interdisciplinary team.

B) A facility shall protect and promote the rights of the resident.

g) The facility shall develop procedures for investigating complaints concerning theft of residents' property and shall promptly investigate all such complaints. (Section 2-103 of the Act)

This REQUIREMENT is not met as evidenced by:

Based on interview and record review the facility failed to complete a thorough investigation into a suspected drug diversion. The facility also failed to report a suspicion of a drug diversion to law enforcement. This applies to three of three residents (R1-R3) who reside on the sheltered care unit reviewed for narcotics in the sample of 13.

The findings include:

The facility census for the sheltered care unit dated 1/21/25 shows there are 36 residents in the facility.

1.) R1's face sheet showed she was admitted on

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3/21/24 with diagnoses to include anemia in chronic kidney disease, anxiety disorder, chronic kidney disease, hyperlipidemia, hypertensive chronic kidney disease, primary generalized osteoarthritis, and dementia. R1's physician order sheet showed an order for lorazepam (anti-anxiety medication) to be given every 4 hours as needed and morphine sulfate (opioid pain medication) to be given every hour as needed.

R1's controlled drug receipt/record/disposition form showed 5 ml (milliliters) of morphine sulfate was received at the facility on 9/28/24 and 5 ml of morphine sulfate was destroyed on 12/31/24. R2's controlled drug receipt/record/disposition form showed 5 ml of lorazepam was received at the facility on 9/28/24 and 4.0 ml was destroyed on 12/31/24.

2.) R2's face sheet showed he was admitted to the unit on 12/24/24. R2's face sheet had no diagnoses listed. R2's medical record showed he had diagnoses to include anemia, chronic anticoagulation, insomnia, hypomagnesia, coronary artery disease, bradycardia, generalized weakness, and angiodysplasia of stomach and duodenum.

The facility provided a copy of a packing slip from the hospice pharmacy dated 12/17/24 which showed morphine sulfate and lorazepam were sent to the facility for R2. The facility was unable to provide the drug receipt/record/disposition form for either the lorazepam or the morphine sulfate delivered on 12/17/24.

The manifest provided by the hospice pharmacy received on 1/28/25 shows a 5 ml bottle of lorazepam 2mg/ml, and a 5 ml bottle of morphine

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20mg/ml was delivered to the facility on 12/17/24 and signed by a facility nurse (V15 Registered Nurse) as receiving.

On 1/28/25 at 12:37 PM, V3 said the forms and the drugs were never located. The nurse that signed for it when it was delivered should have pulled the morphine and lorazepam out of the comfort box and began counting it in the shift-to-shift narcotic counts.

3.) R3's face sheet showed she was admitted on 5/12/22 with diagnoses to include acute on chronic diastolic congestive heart failure, hypertensive heart disease, nonrheumatic aortic valve stenosis, atrial fibrillation, and dementia.

R3's Individual Controlled Substance Record showed 30 ml of lorazepam was received at the facility 6/21/24 and 30 mls was destroyed on 12/31/24. R3's Individual Controlled Substance Record showed 5 ml of lorazpam was received at the facility on 12/13/24 and 5 ml was destroyed 12/31/24. R3's Individual Controlled Substance Record showed 5 ml of morphine sulfate was received at the facility 12/13/24 and 5 mls was destroyed 12/31/24.

The facility provided an email dated 12/25/24 at 8:26 AM, which showed it was from V3 (Director of Nursing/DON) to V1 (Administrator). The email showed, "... this morning, [V4 LPN (Licensed Practical Nurse)] called me with concerns regarding a nurse on [sheltered care unit] for night shift. The nurse was [V21 Agency LPN]. She stated that a CNA (Certified Nursing Assistant) stopped her prior to clocking in and told her the nurse she was working with on nights was "all over the place" and was caught sleeping 3 times. I was not notified of any of this

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throughout the night and neither was the nurse on call. She said the office was in complete disarray and she noticed discrepancies in the narcotic count. She forgot to sign out an Ambien (sleep medication), but I did verify with another nurse that this was given, and the count was corrected. [V4] stated a bottle of Norco (opioid pain medication) was unaccounted for but they did locate it in the other narcotic drawer prior to the nurse leaving. [V4] also stated an oxycodone (opioid pain medication) count was off but the pill was located in the bottom of the drawer and count was correct. [V4] stated when they counted the liquids in the fridge, she noticed the consistency seemed off and stated the liquids smelled of "mouthwash and [cough medication]." I did let her know that the narcotics sent from hospice in comfort packs did have a "sweet" smell. [V4] stated the nurse kept "looking around the unit like she lost something" and I advised her that if she did not leave, to please have maintenance escort her out if need be. She did end up leaving on her own accord. I have removed her from her double shift today and will notify her agency about the above. I will also check our policy for suspected medication diversion and consult with pharmacy as the need arises. Please let me know if there is anything you need from me at this time..."

The facility provided an email thread dated 12/31/24 at 7:43 AM which showed V8 (Pharmacy Nurse Consultant) contacted V3 (DON). This email showed, "... Can you please call me this morning... we received a call from a nurse, [V4]. She is concerned that 2 residents morphine/lorazepam liquids from the hospice kit were switched with water and is asking if there is a way to test it..." On 12/31/24 at 8:46 AM, V4 (LPN) was added to the email and additionally V5

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(LPN Nurse Manager) and V1 (Administrator) were copied. This email showed, "[V4], I spoke with [V8 Pharmacy Nurse Consultant] this morning. She confirmed there is no test to check the morphine/lorazepam. She consulted with the pharmacist and best practice would be to document (which we have) and ask hospice or pharmacy to supply a new bottle. I am attaching the policy we follow from [the pharmacy]... All proper documentation has already been filed and her agency has already disabled her account. We likely won't know what comes of this for quite some time but we do have all the information we need to move forward... [V5 LPN Nurse Manager] can we please dispose of the narcotics we believe have been tampered with and ensure hospice is able to send a new bottle?..."

On 1/22/25 at 10:30 AM, V4 said, "On Christmas morning when I came in, one of the CNAs reported to me that they had a hard night with [V21Agency LPN]. [V21] and I went into the nursing office together and it was a mess. She asked me if everything was okay. I went to the desk to get report and [V21] was sitting in a chair with wheels. [V21] wheeled the chair over to the medication cart and she was going through the drawer. I heard her 'pop' a pill. I went over to cart, and she had a pill in her hand. I heard her drop the pill. I took the pill and put it in a medication cup. I verified what it was with the numbers on the pill. It was oxycodone. She said she did not know where it came from. I told her it came from her hand. When we started counting, one card was off by 1 tablet, and we did 'correct count' on that one. Then when the 2nd, 3rd, and 4th were off by 1, I got on the phone and called [V3 Director of Nursing]. [V21] had the narcotic book and she signed off medications as we went with different times and dates. The dates weren't

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correct. One she dated 12/22 and one she dated 1/4, and one she signed out 12/16 with my name. I didn't sign that. She spelled my last name wrong. I took copies of the sheets. There was a Norco on the floor. I shut the drawer and said, 'we are done'. I'm not correct counting any more of these. The liquids were too thin, watered down. I took the lorazepam to [V19 LPN] and told her something was wrong with it. It smelled like mouthwash. When I came back to the unit she asked if 'everything was fine' I told her no, she was all over the place, back and forth. She should have left but the units were calling and saying she was coming through the there. She came back and said she was 'looking for her lunch', said it repeatedly to me and was pointing at the medication refrigerator and repeating 'that's okay right'. I told her again that 'no' it was not alright, and she asked me how I would know if it was mouthwash or water. I asked her if she gave the diabetics their insulin, she said she didn't because none of their blood sugars were high enough. On the side of the cart there is a recycle bin for our medication slips with resident names on them and I found all her 6 AM medications in that trash. She had not passed any of her 6 AM medications. I told [V20 Executive Director] about that and wrote a statement, contacted V3 (DON) and forwarded everything to V1 (Administrator), V3 (DON), and V20 (Executive Director). Seven days later I called pharmacy because we were still counting the medications that were tampered with. We destroyed a total of 6 medications I believe..."

On 1/21/25 at 2:10 PM, V19 (LPN) said, "I was working day shift on Christmas... V4 came to me with a bottle of lorazepam and wanted to see if I thought the lorazepam had been tampered with. The bottle was open, and I opened it and smelled

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it. It smelled like mints. The consistency was 'off' as well, it looked thinner than normal. The liquid amount was off too. It was higher than 30cc."

On 1/21/25 at 2:22 PM, V5 (LPN Nurse Manager) said, "... [V4] called me and told me the counts were off and the liquid medications looked like they had been tampered with. I made sure she called the DON. A day or 2 later, I was asked by the DON to waste the medications. [V4] and I destroyed the medications. I think there were 2-3 bottles. When we wasted the medications, it was hard to tell if it really was morphine and lorazepam. They had a minty or spearmint smell..."

On 1/22/25 at 2:31 PM, V15 RN (Registered Nurse) said she worked second shift on the sheltered care unit on Christmas Eve. V15 said V21 (Agency LPN) was the nurse taking over the unit. V15 said, "[V21] was not focusing, kept talking over me while I was giving her report and counting. We counted and there were 3 patients with liquids in the refrigerator. [R2] had morphine and lorazepam in the refrigerator..." V15 said she was made aware of the concern regarding medications being tampered with and she did see the medications in question. V15 said the morphine was a dark red color. V15 said, "It was different than it was. I told them it is very important to report this to management because it is reportable to state... She said she had already reported to them. It looked different to me. The color was not right. I felt it was changed..."

On 1/21/25 at 11:30 AM, V1 (Administrator), said, "We got reports of an agency nurse sleeping while on duty and possibly taking drugs. We could not prove that this happened. (Drug tampering

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and diversion). It is one person's word against another. We didn't report to (state surveying agency) or the police because we couldn't prove it. The facility could get sued for slander if we start claiming she did this."

On 1/21/25 at 11:30 AM, V3 (DON) said they reported this concern to the agency the nurse worked for. An investigation was done. Pharmacy was called and asked if they could test the morphine or Ativan (lorazepam) and they said they did not have the ability to do that but to replace the drugs.

On 1/21/25 at 2:49 PM, V20 (Executive Director) said she was in the building on Christmas morning (12/25/24). "[V4] told me what was going on. She was very upset and said the nurse was sleeping, not being attentive to the residents and the medication counts were off. I confirmed with her that the DON had been notified."

On 1/22/25 at 1:33 PM, V10 (Registered Nurse/RN) said she was working overnight on 12/24/24 through 12/25/24. V10 said V21 (Agency LPN) was having difficulty signing into the computer system when she first arrived so she saw her at the beginning of her shift. V21 said at that time she didn't notice anything out of the ordinary regarding V21. V10 said the next time she saw V21 was when the CNAs (Certified Nursing Assistants) that were working with V21 came and got her because V21 was in the nursing office with the door locked. V10 said she went to the unit and unlocked the door.

On 1/21/25 at 3:20 PM, V6 (RN) said he worked the night shift on [the healthcare unit] over 12/24/24 and 12/25/24. V6 said when he arrived on his unit the nurse he was relieving [V21

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Agency LPN] was on the first floor. He said the counts were off, so he had her come and count. V6 said V21 told him she had not signed out the medications she had given so she was signing them out then. V6 said, "She was not making much sense. Then she disappeared. I went down to talk to [V4 LPN/Charge Nurse] and she was upset. She had found pills on the ground and said the consistency was off on the liquid medications, the color was off, and it smelled like [cough syrup]. We compared it to the stock cough syrup, and it smelled the same... When I went back upstairs, [V21] was walking up and down the stairs, trying to get into the unit fridge... The maintenance man then came to the unit looking for [V21] and escorted her out of the building. She was clearly 'on something'."

On 1/22/25 at 12:19 PM, V7 (Maintenance) said he was called over to the radio on Christmas Day to remove a nurse who was acting erratic. V7 said, "I was told her shift was done and she needs to leave the building right away. She was trying to outrun me, but I cut her off since I know the building well and told her she needed to leave. She was acting strange... Her pupils were extremely dilated. She was acting like she took some 'gummies' or something. She didn't smell like anything, but she was acting erratic... I took her to the exit, but I didn't think she was going to leave. She sat in her car for at least 10 minutes, just sitting there. So, I picked up the phone to act like I was calling someone, and she then she headed out. I followed her for a bit just to make sure she left... No one at the facility has asked me anything about this..."

On 1/24/25 at 10:57 AM, V18 (Pharmacist) said R2's comfort pack was delivered to the facility

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and signed for by (V15 RN) on 12/17/24 at 5:40 PM. V18 said the contents of comfort pack included morphine sulfate liquid and lorazepam liquid in addition to other comfort medications. V18 said the hospice company called and reordered another bottle of liquid morphine and lorazepam on 12/26/24. V18 said liquid morphine sulfate appears light reddish pink in color, has a slight cherry flavor, and no scent. V18 said liquid morphine does not at all smell like cough syrup. V18 said the liquid lorazepam that was provided to the facility was completely clear, has a very light mint flavor, and no real discernable scent. V18 said liquid lorazepam does not smell like mouthwash. On 1/28/25 at 2:02 PM, V18 said, "There have been no issues regarding not sending medication that is included on the resident's pharmacy delivery manifest. If it is on the manifest, it was in the comfort box."

On 1/22/25 at 3:30 PM, V3 (DON) said she was not aware that anyone opened R2's comfort kit before so she was unable to confirm if there was morphine and lorazepam in the kit. V3 said she was told by V4 that the comfort kit was sealed when he transferred to the unit, and they don't know when the box was opened. V3 confirmed she had discussed R2's medications with V4. V3 said she had received a call from V4 saying she did not want V21 (Agency LPN) to return because she was confused and left a mess... V4 had reached out to the pharmacy and the pharmacy emailed her and said there was no testing they could do to check to see if the medications were tampered with and they should dispose of the medications and reorder. V3 said, "this isn't diversion or tampering because there is no way to prove that something had been done to these medications. I didn't think there was anything to report. I spoke to the other nurses about their

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opinions but that is just opinions. I'm not saying I don't believe them; I'm just saying there is no way to prove it... after I spoke with V4 a lot of people said [V21] was 'off'. I told them even if someone is just sleeping, they should just send them home. There were medications in the side bin of the medication cart that were not passed or 5 or 6 residents. V3 (DON) said "The police were never notified; this isn't diversion or tampering because there is no way to prove that something had been done to these medications.

The facility's policy and procedure dated March 2021 showed, "... Discrepancies, Loss, and/or Diversion of Medications; Policy: All discrepancies, suspected loss and/or diversion of medications, irrespective of drug type or class, are immediately investigated and report filed. Procedures: A. Immediately upon the discovery or suspicion of a discrepancy, suspected loss of diversion, the Administrator, Director of Nursing (DON) and Consultant Pharmacist are notified, and an investigation conducted. The Director of Nursing leads the investigation... C. Loss of a supply of a medication; 1) The DON investigates the suspected loss and researches all the records related to medication receipt, its use since receipt, all persons involved with medication administration and the supply of the medication, and identified the last known point in time that the medication was available. The dispensing pharmacy should be notified, and the pharmacy should verify that the medication was actually dispensed. A thorough search in all drug storage areas, the resident's room and other locations where medications may have been used/placed during the medication administration are made to locate any missing container or medication supply. 2) After a thorough investigation has been

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S9999	Continued From page 12	S9999		

completed and the supply cannot be found, a supply must be obtained for the resident... 3 Document the loss and the investigation process... If the loss involves a controlled substance, all the controlled drug accountability procedures and documentation should be reviewed and audited. 4) If the audit reveals a particular individual(s) who might be suspected of involvement with the loss, appropriate disciplinary actions are taken and deferred to human resource policies. 5) Appropriate agencies, required by state and federal law will be notified. D. Notification of Agencies; 1) If diversion is suspected, or upon verification that discrepancy in a drug count or loss of supply is a result of diversion, the administrator must notify the (state surveying agency) of the ongoing investigation. As diversion of medication falls under the misappropriation of resident belongings, a policy report should be made. In the case of controlled substance discrepancy or loss, local law enforcement will determine when DEA notification is necessary..."

The facility's policy and procedure with revision date of 7/2024 showed, "... Medications: Storage of and narcotic counts; Purpose: To establish uniform guidelines concerning the storing of drugs and biologicals; Policy Statement: All medications for our residents/patients must be stored in a locked area.... All scheduled II-V Controlled medications will be counted with 2 nurses at each shift change and any discrepancies/corrected counts will be initialed and dated by both nurses. DON (Director of Nursing) and administrator to be notified of any narcotic discrepancies in real time for investigation to be conducted. All narcotics should be signed out in real time, upon administration..."

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6010037	A. BUILDING: _____ B. WING _____	C 01/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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S9999	Continued From page 13	S9999		

The facility's policy and procedure with review date of 8/2024 showed, "... Abuse and Neglect Prevention Protocol Policy; Policy: It is the policy of this facility to not tolerate abuse of neglect of its residents by any individual. The Administrator, Director of Nursing and Director of Social service shall be responsible to direct and coordinate action against all abuse and neglect activities within the facility. All residents/representatives shall be notified of the content of this policy upon admission... The following policy definitions, criteria and guidelines shall be used to determine abuse, neglect and related reporting requirements as provided... 11. Misappropriation of resident property means using a resident's cash, clothing, or other possessions without authorization by the resident or the resident's authorized representative... Documentation of Suspected Abuse; All reports of abuse or neglect shall be documented on the Incident Report Form. This form is located at the Nurse's Station. The report is to be reviewed by Abuse Prevention Coordinator or designee. The Administrator (or in his absence, his designee) will be informed immediately. All alleged reports of abuse or neglect shall be reported by phone or fax to (state surveying agency) in a timely manner (within 2 hours of an allegation if it involves serious injury; otherwise, no later than 24 hours) with an investigative report to follow. Investigation will be performed by Abuse Prevention Coordinators including but not limited to interviews of residents and staff members. Following an investigation, a report will be submitted to (state surveying agency) within 5 days. The Abuse Prevention Coordinators are responsible to make sure all internal and State reporting requirements are done properly and timely. The Abuse Prevention Coordinators will also be responsible to provide

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S9999	Continued From page 14 feedback to the referral party to show the seriousness of the investigation findings... REPORTING OF SUSPECTED ABUSE: ... Evidence may include witnesses who personally observed and witnessed the incident or other credible evidence found in the investigation such as physical evidence..." "B"	S9999		