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	146086	A. BUILDING _____ B. WING _____	C 08/06/2021

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TUSCOLA HEALTH CARE CENTER	**1203 EGYPTIAN TRAIL TUSCOLA, IL 61953**

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F 000	INITIAL COMMENTS Complaint 2165547/IL136690 F757 Investigation of Facility Reported Incident of 7/14/21/IL136530 F689 Investigation of Facility Reported Incident of 7/20/21/IL136533 F602	F 000		
F 602 SS=D	Free from Misappropriation/Exploitation CFR(s): 483.12 §483.12 The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. This REQUIREMENT is not met as evidenced by: Based on record review and interview the facility failed to ensure R1 and R7's prescribed controlled substance medications were accounted for and not subjected to misappropriation or diversion. R1 and R7 are two of seven residents reviewed for misappropriation of the sample of twelve. Findings include: R1's undated Face Sheet documents an admission date of 5/6/13 with diagnoses: Arthritis, History of Open Reduction Internal Fixation (ORIF) of Left Hip, Osteoarthritis and Osteoporosis. R1's Physician Order Sheet (POS) dated:	F 602	1. Corrective Action for the alleged deficient practice has been achieved by the following: A. R1□s Norco was discontinued due to lack of use and destroyed according to facility procedure.(Attachment A) B. R7□s discontinued Ativan was secured due to on-going investigation by ISP. C. All narcotics were reconciled upon notification of missing Norco. D. All narcotics were reconciled upon notification of missing Ativan. E. Local Authorities and Special Agent with the ISP Medicare/Medicaid Fraud Unit was notified. E. Facility implemented process of	8/27/21

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

Electronically Signed | 08/27/2021

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F 602	Continued From page 1 September 1-30, 2020 documents a Physician order for Hydrocodone-Acetaminophen (Norco) 5-325 milligrams (mg) give one half tablet (tab) every morning and before bed. This same POS documents a Physician order for Norco 5-325 mg every four hour as needed. October 1-31, 2020 documents a Physician order for Norco 5-325 mg give one half tablet every AM and a separate Physician order for Norco 5-324 mg every four hours as needed. November 1-30, 2020 documents a Physician order for Norco 5-325 mg give one half tablet every morning and every four hours as needed. R1's scheduled Norco 5-325 mg Physician order was discontinued on 11/11/20. R1's Pharmacy Delivery Receipt Inventory sheet dated 9-9-2020 documents 90 half tabs of Norco 5-325 mg were delivered to and received by facility on 9/9/20. These 90 half tabs of R1's Norco 5-35 mg were distributed on four separate medication cards carrying 24, 22, 22 and 22 Norco 5-325 mg half tabs of pills. This same Inventory sheet is signed as being received by facility nurse V28 Licensed Practical Nurse (LPN) on 9/9/20. R1's Controlled Substance Proof of Use Sheets (pink sheets) generated by facility dated 9-9-2020 document receipt of 24 Norco half tabs on one pink sheet and 22 Norco half tabs on pink sheet. These pink sheets were both dated 9/9/20 and accounted for 46 total Norco 5-325 mg half tabs administered to R1. On 8/2/21 at 3:40 PM V1 Administrator stated when V8 LPN came in to work evening shift on	F 602	monitoring and counting all Controlled Substance Proof of Use Sheets. F. Nurses were in-serviced on 8/10/21 regarding facility policy for Controlled Substances and Destruction of Controlled Medications. (Attachment B) 2. All residents who receive controlled medications had the residents have the potential to be affected by the alleged deficient practice. However, due the implementation of 1 C-F, the alleged deficient practice will not recur. 3. The following systematic processes were implemented: A. Facility Abuse Prevention Policy was reviewed and was found to be in compliance with federal regulations. B. Facility implemented process of monitoring and counting of all Controlled Substance Proof of Use Sheets. C. Administrator will do random audits of narcotic count and Controlled Substance Proof of Use Sheets. 4. The following Quality Assurance programs have been implemented to ensure continued compliance is maintained: A. The allegations of suspected misappropriation are to be reported to the Regional Clinical Director to ensure that the facility Abuse Prevention Policy and Procedures are being executed. B. Facility will monitor compliance	

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F 602	Continued From page 2 7/20/21, V8 LPN counted narcotics with the previous shift nurse V7 LPN. V1 stated at that time V8 reported some of her (R1) Norco 5-325 mg were missing. V1 stated pink sheet and narcotic count sheet for R1's Norco were missing (and could not be accounted for) and were most likely destroyed by the former Director of Nursing. On 8/3/21 at 6:50 PM V8 LPN stated "I (V8) noticed that she (R1) was missing 14 Norco half tabs at the 2:00 PM narcotic count on 7/20/21 when counting with V7 LPN. We (V7 and V8) searched the medication rooms, medication carts, narcotic destruction notebook, through other residents' pills for her (R1) missing Norco. I (V8) am 100% certain that card of 14 Norco half tabs existed. The regular nurses on that hall all agree it (card of 14 Norco half tabs) was there and then it wasn't (and could not be accounted for). The other nurses are not regulars on that hall." On 8/4/21 at 3:00 PM V17 Pharmacist stated "The pharmacy sent her (R1) 90 half tabs of Hydrocodone-Acetaminophen (Norco) 5-325 milligrams (mg) on 9/9/20, 60 half tabs of Norco 5-325 mg on 9/19/20 and 30 half tabs of Norco 5-325 mg on 11/11/20. We (pharmacy) have not sent her (R1) any Norco since 11/11/20. On 8/4/21 at 3:30 PM V1 Administrator stated "I (V1) reviewed the pink sheets for her (R1) during the investigation but did not look at them thoroughly. I (V1) didn't realize there were 90 half tabs delivered on 9/9/21. I (V1) was only looking at her (R1) Norco delivered on 9/19/20 and 11/11/20 which was accounted for." R3's undated Face Sheet documents an	F 602	through the internal QA process.	

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F 602	Continued From page 3	F 602		

admission date of 7/7/21. This same Face Sheet documents diagnoses of: Diabetes Mellitus, Anxiety and Agitation.

R3's Minimum Data Set (MDS) dated 7/13/21 documents a Brief Interview for Mental Status score of 11 out of 15 possible points indicating moderate cognitive impairment.

R3's Physician Order Sheet (POS) dated July 1-31, 2021 documents a Physician order for Ativan 2mg/ml Give 0.3ml (0.6mg total) by mouth every six hours as needed for agitation. May repeat after 30 minutes if not effective.

R3's Controlled Substances Proof of Use sheet dated 7/22/21 documents 30 milliliter (ml) were received by Pharmacy and a total of 3.5 ml were administered to R3 by Physician order. The last entry was made on 8/2/21 at 4:20 PM documents "bottle secured" with 16.0 ml Ativan 2 mg/ml remaining in bottle.

On 8/2/21 at 12:50 PM V12 Registered Nurse (RN) counted R3's liquid Ativan in bottle provided by Pharmacy. R3's Ativan 2 mg/ml bottle was filled to the 16.0 milliliter (ml) mark. R3's Ativan 2 mg/ml narcotic count sheet documented there should have been 26.5 ml left to be administered.

On 8/2/21 at 12:52 PM V12 RN confirmed this discrepancy and stated 'to my knowledge this bottle of Ativan has not been spilled or leaked. The count should match, and it doesn't." The missing 10.5 ml of Ativan could not be accounted for.

ON 8/6/21 at 2:00 PM V1 Administrator stated on 8/2/21 (R3's) "Ativan 2mg/ml was noted to be

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F 602	Continued From page 4 10.5 ml less than the Controlled Substance Proof of Use sheet documented. We (facility) immediately began an investigation and reported to all appropriate authorities, Physician and family. V1 stated R3's Ativan order was discontinued on 7/27/21. I (V1) am still working on the investigation as the Final Investigation Report is not due yet." The facility policy titled 'Abuse Prevention Program' revised 11/28/16 documents the following: "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. All missing items need to be investigated according to the facility's Missing Items Policy."	F 602		
F 689 SS=G	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on record review and interview the facility failed to transfer one (R2) resident safely by not using the appropriate sized sling for a mechanical lift. This resulted in R2 falling from the mechanical lift during a staff assisted transfer to	F 689	1. For the resident (R2), found to be affected by the alleged deficient practice the following was implemented: A. Nursing staff was in-serviced on safe resident transfers, Mechanical Lift and	8/27/21

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F 689	Continued From page 5 the floor and R2 sustaining a fractured left ankle. R2 is one of three residents reviewed for falls in a sample list of 11 residents. Findings include: R2's undated Face Sheet documents diagnoses of: Cerebral Vascular Accident (CVA), Impaired Mobility, Deafness, Wheelchair Dependent, and Weakness of Left Arm. R2's Minimum Data Set (MDS) dated 2/2/21 documents a Brief Interview for Mental Status score of 15 out of 15 possible points indicating intact cognition. This same MDS documents R2 requires total dependence of two staff for transfers. R2's Care Plan dated 5/7/20 documents "Advise resident (R2) what is expected during the transfer. Reassure resident (R2) of safety as needed. Keep hand on resident (R2) to reassure safety as needed. Ensure lift sheet is intact and correct size for resident." R2's Physician Order Sheet (POS) dated July 1-31, 2021 documents a physician order to "Obtain X-Ray of Left Ankle. Three views AP, oblique and lateral. Portable due to decreased mobility and health. Diagnosis: edema and complaint of pain." This same POS documents another Physician order to "Send to Emergency Room for fracture of Left Ankle and Pain Control." R2's X-Ray report dated 7/14/21 documents "Findings: A fracture is noted involving the Medial Malleolus. The fracture abuts the articular surface. Anterior medial displacement of the distal fracture fragment is noted. The ankle	F 689	proper use of slings. (Attachment A) B. Nurse Management initiated return demonstration for proper use of Mechanical Lift and correct size of sling being used. (Attachment B) 2. Residents who utilize a Mechanical Lift have the potential to be affected by the alleged deficient practice, however, with the implementation of 1A-B, the alleged deficient practice will not recur. 3. To ensure that proper practices continue the following systematic measure has been implemented: A. Nursing management will do random observations of transfers with a Mechanical Lift to ensure facility Policy and Procedure for Mechanical Lift is followed. (Attachment C) 4. The following QA programs are in place to ensure compliance: A. All falls will be reviewed during morning QA meetings to identify any needs in ongoing education and appropriate interventions are developed based on the root cause of a fall. B. Compliance will be monitored through the internal QA process.	

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F 689	Continued From page 6	F 689		

mortise is intact. Degenerative changes are present. Osteopenia is noted. The surrounding soft tissues are normal. Impressions: Fracture involving the Medial Malleolus. Clinical Correlation and follow up are recommended. Chronic and degenerative changes."

R2's Final Abuse Investigation Report dated 7/21/21 to the state agency documents R2 "was being transferred with the mechanical lift when she (R2) slid out of the sling onto the floor. X-Ray of the Left ankle obtained showing fracture involving the medial malleolus, chronic and degenerative changes."

R2's After Visit Summary dated 8/2/21 documents "Use a fracture boot, adjusted to comfortably snug. Keep the boot on as tolerated for the next six weeks, except while bathing."

On 8/3/21 at 2:20 PM V13 Certified Nurse Aide (CNA) stated V13 and V25 CNA's assisted R2 out of bed into wheelchair using a mechanical lift on 7/14/21. V13 CNA stated tried to get R2's mechanical lift sling to fit several times "but it was too small. We (V13 and V25) raised and lowered (R2) over bed several times trying to adjust the sling. The sling we (V13, V25) used was a six-point sling, but it was too small to criss cross between her (R2) legs, so we (V13, V25) didn't criss cross the sling. It (sling) barely covered her (R2) buttocks. We (V13, V25) thought it would be ok to just go to the wheelchair, but it wasn't. She (R2) slid out of the sling and fell on the floor. She (R2) broke her ankle. If we (V13, V25) would have just got a bigger sling, she (R2) wouldn't have fallen and broken her (R2) ankle."

On 8/3/21 at 3:30 PM V1 stated "nursing staff

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F 689	Continued From page 7 should always use the correct size of sling for mechanical lift and (R2's) fall and fracture would have been prevented if correct size sling was used during 7/14 transfer." V26 Physician stated on 8/4/21 at 2:45 PM "If the staff used the correct size of sling for the patient (R2), the fall and fracture would have been prevented. (R2's) Osteopenia and chronic changes would not have caused this fall due to the fall was related to the failure of the staff to use the appropriate size sling for this patient (R2). This fracture was not caused by the chronic degenerative changes. The fracture was caused by the fall. This fall will most likely cause the patient (R2) chronic discomfort due to probable ligament injury and documented fracture of medial malleolus of Left Ankle." The facility policy titled 'Mechanical Lift' revised 10/30/08 documents the following: "The mechanical lift may be used to lift and move a resident with limited mobility during transfer while providing safety and security for residents and nursing personnel. Place sling straps under thighs and cross."	F 689		
F 757 SS=D	Drug Regimen is Free from Unnecessary Drugs CFR(s): 483.45(d)(1)-(6) §483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used- §483.45(d)(1) In excessive dose (including duplicate drug therapy); or §483.45(d)(2) For excessive duration; or	F 757		8/27/21

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F 757	Continued From page 8 §483.45(d)(3) Without adequate monitoring; or §483.45(d)(4) Without adequate indications for its use; or §483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or §483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. This REQUIREMENT is not met as evidenced by: Based on record review and interview the facility failed to monitor and document behaviors for residents on Psychotropic medications for one (R11) of three residents reviewed for Resident injury related to behaviors. Findings include: R11's undated Face Sheet documents an admission date of 5/10/21. This same Face Sheet documents diagnoses of: Dementia, Agitation and Parkinson's' Disease. R11's Minimum Data Set (MDS) dated 61/3/21 documents a Brief Interview for Mental Status score of 7 out of 15 possible points indicating moderate cognitive impairment. R11's Physician Order Sheet (POS) dated July 1-31, 2021 documents a Physician order for Duloxetine Hydrochloride (HCL) (antidepressant) delayed Release (DR) 30 milligrams (mg) daily and Quetiapine (antipsychotic) 12.5 mg daily.	F 757	1. For the resident (R11) identified to potentially be affected by the alleged deficient practice, the following corrective actions were taken: A. SSD was in-serviced on Behavior Monitoring Forms and establishing resident centered interventions for behaviors. (Attachment A) B. Nursing staff was in-serviced on documenting identified behaviors and effectiveness of the interventions. (Attachment B) C. All residents who receive psychotropic medications were reviewed to ensure that Behavior Tracking is in place, targeted behaviors are identified and resident centered interventions are established. 2. Residents, who have behaviors and receive psychotropic medications have the potential to be affected by the alleged deficient practice. However, due to the implantation of 1 A-C, the alleged deficient practice will not recur.	

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F 757	Continued From page 9 R11's Hospital Emergency Room record dated 7/28/21 documents bruising to multiple areas including Right Shoulder, bilateral arms, bilateral knees, bilateral front thighs and upper chest. R11's Medical Record does not document behavior tracking for R11's Psychotropic medications. On 8/6/21 at 2:00 PM V1 Administrator stated "Her (R11) behaviors are the primary cause of her (R11) bruises. She (R11) gets combative, hits staff and frequently refuses care. The facility has not been tracking any behaviors for any residents on Psychotropic medications. There is no documentation of behaviors other than what is in the Nurse Progress Notes. We (facility) are a small staff who all know the residents very well. They (staff) report verbally to Physician with changes in behaviors and he the Physician initiates, adjusts or discontinues medications according to staff verbal report. The last behavior tracking the facility has completed was in April of 2021. Our Psychotropic medication policy was not followed." The facility policy titled 'Psychotropic Medication Policy' revised 11/28/17 documents the following: "Definition of a Psychotropic medication: Medication that is used for or listed as used for antipsychotic, antidepressant, antimonic, antianxiety, behavior modification or behavior management purposes. The behavioral tracking sheet of the facility will be implemented to ensure behaviors are being monitored."	F 757	3. The following systematic measures have been implemented to ensure the alleged deficient practice does not recur: A. Nursing Management and IDT will monitor Behavior Tracking Forms to ensure that accurate behavior documentation is being completed. (Attachment C) B. IDT will develop appropriate interventions for any newly identified behaviors and ensure that Behavior Tracking is in place. 4. The following Quality Assurance programs have been implemented to ensure continued compliance: A. Residents receiving Psychotropic Medications for behaviors and any newly identified resident behaviors will be discussed during weekly Psychotropic Medication/Behavior QA meetings. Continued monitoring of Behavior Tracking will also be reviewed during these QA meetings. B. Compliance will be monitored through the internal QA process.	