STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145733	A. BUILDING ______ B. WING ______	C 03/31/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JERSEYVILLE MANOR	**1251 NORTH STATE STREET JERSEYVILLE, IL 62052**

(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) COMPLETION DATE
F 000	INITIAL COMMENTS Complaint Investigation #1541367/IL75705- No deficiencies. Complaint Investigation #1541359/IL75695- F225, F226, F309, F431.	F 000		
F 225 SS=E	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated	F 225		

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

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients . (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 225	Continued From page 1	F 225		

representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.

This REQUIREMENT is not met as evidenced by:
Based on interview and record review, the facility failed to thoroughly and timely investigate potential misappropriation of controlled substance medications, failed to immediately report potential misappropriation of controlled substances to the Administrator, Survey Agency, and Police, and failed to immediately suspend the employee suspected of the misappropriation. These failures have the potential to affect four of four residents (R1-R4) reviewed for medication control in the sample of four and 31 residents (R5-R35) in the supplemental sample.

Findings include:

A computer generated Narcotic Report dated 3/24/15, documents 35 residents have physician orders for narcotic medications.

Interviews with E8 (Licensed Practical Nurse/LPN) , E9 (LPN), E10 (LPN), and E13 (Registered Nurse) on 3/24/15, verified repetitive concerns of E14 (Assistant Director of Nursing) using floor nurses keys to get into the locked narcotic boxes and destroying narcotics without a witness. E8, E9, E10, and E13 all stated their concerns with E14 were not reported to the Administrator.

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On 3/26/15 at 11:00 a.m., E14 (Assistant Director of Nursing) stated E14 was not suspended until 3/17/15 around 10 a.m. E14 stated "(E1-Administrator) let me go to a meeting that started at 6:30 a.m. and then I went to my office to work on charting for a while before (E1) suspended me."

On 3/24/15 at 10 a.m., E1 (Administrator) verified E14 (Assistant Director of Nursing was not suspended until 3/17/15. E1 stated E14 came to work on 3/17/15 and attended a meeting that morning but was suspended by E1 after the meeting. E1 stated there was a chance that E14 could have come in the facility on 3/14/15 through 3/16/15, even though E14 was not scheduled to work. E1 stated "I don't know what policy I would follow with a suspicion of drug diversion." E1 stated misappropriation of narcotics is a criminal act. E1 stated, "(E14) is stealing from the resident. I probably should have reported this incident to the (Survey Agency). I don't know how long I have to complete this investigation." E1 verified the licensed nurses have not been inserviced on misappropriation of medications or reporting such suspicions, since the 3/13/15 incident with E14.

1. A Controlled Substance Shift Change Count-Check Sheet, dated 12/2015, documents R4 had two cards of controlled substances (Vicodin)removed from the narcotic box on 12/19/15 at an unknown time.

On 3/26/15, E6 Licensed Practical Nurse-LPN), E12 (LPN), and E14 (Assistant Director of Nursing) verified E3 (Director of Nursing) was notified of R4's missing Vicodin.

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On 3/26/15 at 8:23 a.m., E1 (Administrator) stated E1 was not aware of R4 having any medication missing. E1 stated "I should have been notified if any staff were aware." E1 verified neither the Survey Agency or the local police department were notified of potential misappropriation of controlled substance medications. E1 stated this could be considered a criminal act. E1 stated E14 (Assistant Director of Nursing) should have been suspended immediately.

On 3/26/15 at 11:00 a.m., E14 (Assistant Director of Nursing) stated, "I'm not sure what medications I took out of (R4's) narcotic box. I don't know why I was in (E6's-LPN) medication cart. I know I talked to (E3) about this the following Monday morning (12/22/14)."

2. R1's Physician Order Sheet dated 3/15, documents R1 receives Vicodin 5/325 milligrams (mg) one tablet by mouth four times per day as needed. R1's Controlled Substance Record dated 3/9/15, documents E14 signed out two of R1's Vicodin on 3/13/15 at 10 a.m.

On 3/24/15 at 11:30 a.m., E3 (Director of Nursing) stated that on 3/13/15 at approximately 10 p.m., E7 (Licensed Practical Nurse) reported that E14 (Assistant Director of Nursing) had signed out two Vicodin from R1's supply that R1 did not receive. E3 stated E3 and E2 (Assistant Administrator) came to the facility on the following day (3/14/15) to start an investigation. E3 stated "we interviewed (R1) and three other nurses on 3/14/15." E3 stated that the interviews on 3/14/15

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F 225	Continued From page 4 with E8 (Licensed Practical Nurse), E5 (Licensed Practical Nurse), and E9 (Licensed Practical Nurse) verified we had a potential misappropriation of medications by E14 (Assistant Director of Nursing). E3 stated E1 (Administrator) was not notified until 3/14/15 (time unknown). E3 stated "I probably should have notified (E1) on 3/13/15 when I became aware of the problem." E3 stated E14 was not interviewed until E14 returned to work on 3/17/15 at which time E14 was suspended. On 3/24/15 at 1:00 p.m., E3 stated E3 had no knowledge of what policy was being followed to investigate the potential misappropriation of medications. E3 stated "this is potentially a criminal act." E3 stated "I haven't gotten much of the investigation completed but (E14) is still suspended." E3 was unable to provide any documentation regarding the investigation of R1's missing medications other than a timeline E3 "just typed" for the surveyors. When asked if E3 had reviewed controlled substance records or completed medication cart audits, E3 replied "no I haven't gotten far with anything like that." E3 verified that the Survey Agency, R1's family, Pharmacy, or Local Police Department have not been notified of R1's missing medications or a potential misappropriation of controlled substance medications.	F 225		
F 226 SS=E	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.	F 226		

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This REQUIREMENT is not met as evidenced by:
Based on interview and record review, the facility failed to follow its abuse policy related to misappropration of a controlled sustance medication. This failure has the potential to affect four of four residents (R1-R4) reviewed for narcotic use in the sample of four and 31 residents (R5-R35) on the supplemental sample.

Findings include:

An Abuse Prohibition Policy, dated 6/2014, documents the facility actively prohibits resident abuse including neglect, involuntary seclusion, missappropriation of property, and injuries of unknown source...any person who becomes aware of any alleged misappropriation or theft of resident property shall report the incident to the Administrator immediately...the Administrator shall provide the Survey Agency with initial notice of the alleged abuse or neglect as soon as possible but not more than 24 hours after the incident becomes known...the Administrator or designee shall investigate the alleged misappropriation or theft of resident property...the Administrator shall be responsible for supervising the investigation and reporting the results of the investigation to the Survey Agency...the Administrator shall notify the resident's respresentative and/or responsible party of the alleged misappropriation or theft and the results of the facility's investigation of the incident..the Administrator shall immediately contact local law enforcement authorities when a crime or any

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F 226	Continued From page 6 reasonable suspicion of a crime has been committed in a facility by a person other than a resident...and the Administrator shall immediately suspend the employee suspected to be involved in the alleged abuse. A computer generated Narcotic Report dated 3/24/15, documents 35 residents have physician orders for narcotic medications. 1. A Controlled Substance Shift Change Count-Check Sheet, dated 12/2014, documents R4 had two cards of controlled substances removed from the narcotic box on 12/19/14 at an unknown time. On 3/26/15 at 9:00 a.m., E6 (Registered Nurse) stated on 12/19/14, E14 (Assistant Director of Nursing) took E6's keys to the medication cart. E6 stated,"I saw (E14) get into the locked narcotic box and take medication out...E14 did not report giving any medications or destroying any medications....At the end of my shift I noticed (E14) had documented two full cards of (R4's) controlled substance medication had been removed from the narcotic box....I had no way of knowing how many actual pills were missing because (E14) also took (R4's) Controlled Substance Record." At this time, E6 stated the oncoming shift Nurse (E12-Licensed Practical Nurse) witnessed the discovery of R4's missing medications. E6 stated "I immediately called (E3) the Director of Nursing and reported the missing medications and also asked what authority (E14) had to take my keys to the medication cart....(E3) told me to take it up with (E14)." E6 stated that night (12/19/14) E6 attempted to call and text	F 226		

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message E14 with no success. E6 stated E14 approached E6 the following Monday (12/22/14) and told E6 that R4's Vicodin had been destroyed and R4's Controlled Medication Record was left on the nurses desk. E6 stated "I told (E14) that (E12) and I both looked all over the desk and also (E12's) office for the missing Controlled Medication Record and it was no where to be found." E6 stated the Controlled Medication Record or the missing medications were never found to E6's knowledge.

On 3/26/15 at 9:21 a.m., E12 (Licensed Practical Nurse) stated "I was counting narcotics at the change of shift (12/19/14) with (E6) when it was discovered that two cards of R4's Vicodin were missing." E12 stated E6 and E12 looked everywhere for R4's Controlled Substance Record and the two cards of Vicodin. E12 stated "I knew it had not been very many days since (R4) received 180 Vicodin from the pharmacy and now mysteriously they were gone." E12 stated "I was sitting with (E6) when she notified (E3) of the missing Vicodin."

On 3/26/15, E6 Licensed Practical Nurse-LPN), E12 (LPN) verified E3 (Director of Nursing) was notified of R4's missing Vicodin on 12/19/14.

On 3/26/15 at 8:23 a.m., E1 (Administrator) stated E1 was not aware of R4 having any medication missing. E1 stated "I should have been notified if any staff were aware." E1 verified R4's family, the Survey Agency, and the local police department were not notified of potential misappropriation of controlled substance medications. E1 stated this could be considered a criminal act. E1 stated E14 (Assistant Director of Nursing) should have been suspended

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immediately.

On 3/26/15 at 11:00 a.m., E14 (Assistant Director of Nursing) stated, "I'm not sure what medications I took out of (R4's) narcotic box on 12/19/14. I don't know why I was in (E6's-LPN) medication cart. I know I talked to (E3) about this the following Monday morning (12/22/14)."

2. R1's Controlled Substance Record, dated 3/9/15, documents E14 (Assistant Director of Nursing) signed out two Vicodin on 3/13/15 at 10 a.m.

On 3/24/15 at 11:30 a.m., E3 (Director of Nursing) stated that on 3/13/15 at approximately 10 p.m., E7 (Licensed Practical Nurse) reported that E14 (Assistant Director of Nursing) had signed out two Vicodin from R1's supply that R1 did not receive. E3 stated E3 and E2 (Assistant Administrator) came to the facility on the following day (3/14/15) to start an investigation. E3 stated "we interviewed (R1) and three other nurses on 3/14/15." E3 stated that the interviews on 3/14/15 with E8 (Licensed Practical Nurse), E5 (Licensed Practical Nurse), and E9 (Licensed Practical Nurse) verified there was a potential misappropriation of medications by E14 (Assistant Director of Nursing). E3 stated E1 (Administrator) was not notified until 3/14/15 (time unknown). E3 stated "I probably should have notified (E1) on 3/13/15 when I became aware of the problem." E3 stated
E14 was not interviewed until E14 returned to work on 3/17/15 at which time E14 was suspended.

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F 226	Continued From page 9 On 3/24/15 at 1:00 p.m., E3 stated E3 had no knowledge of what policy was being followed to investigate the potential misappropriation of medications. E3 stated "this is potentially a criminal act." E3 stated "I haven't gotten much of the investigation completed but (E14) is still suspended." E3 was unable to provide any documentation regarding the investigation of R1's missing medications other than a timeline E3 "just typed" for the surveyors. When asked if E3 had reviewed controlled substance records or completed medication cart audits, E3 replied "no I haven't gotten far with anything like that." E3 verified that the Survey Agency, R1's family, Pharmacy, or Local Police Department have not been notified of R1's missing medications or a potential misappropriation of controlled substance medications.	F 226		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on interview and record review the facility failed to communicate changes in hospice plan of care with hospice agency for one of one resident (R2) reviewed for hospice services in the sample of four.	F 309		

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Findings include:

The Facility's Hospice Contract, dated 11/20/08, states, "If there are physician orders that are inconsistent with the Plan of Care or hospice protocols, a licensed nurse with the Facility shall immediately notify Hospice."

R2's Election of Benefits for Hospice Care, dated 1/17/15, documents that R2's start of care date for hospice was 1/7/15.

R2's Hospice Team Care Plan, dated 1/23/15, documents that R2 was receiving hydrocodone-acetaminophen 5-325 mg (milligrams) two tablets by mouth every six hours as needed for pain.

R2's Prescription order documents that R2's hydrocodone-acetaminophen 5-325 mg was discontinued on 1/26/15 by E14 (Assistant Director of Nursing).

On 3/25/15 at 3:15 p.m., Z3 (R2's Hospice Registered Nurse) stated, "(R2) was admitted to hospice on 1/7/15, and had the order for the hydrocodone-acetaminophen 5-325 mg order. On 1/26/15, (E14) discontinued the hydrocodone-acetaminophen without discussing it with hospice first. All orders are suppose to go thru hospice first. I found out about this order when I came in that next week for a visit. We planned to keep (R2's) hydrocodone-acetaminophen order when we admitted (R2) to hospice for pain since she was comfort care even if it wasn't being used at the time."

On 3/26/15 at 11:55 a.m., E3 (Director of Nursing)

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F 309	Continued From page 11 stated, "The discontinuing of (R2's) hydrocodone-acetaminophen 5-325 mg should have went thru hospice. Hospice should have been notified prior to the hydrocodone-acetaminophen 5-325 mg being discontinued."	F 309		
F 431 SS=E	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the	F 431		

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quantity stored is minimal and a missing dose can be readily detected.

This REQUIREMENT is not met as evidenced by:
Based on record review and interview the facility failed to follow the pharmacy policy related to destroying medications and possession of keys to controlled substances. This failure has the potential to affect four of four residents (R1-R4) reviewed for narcotic use in the sample of four and 31 residents (R5-R35) on the supplemental sample.

Findings include:

A computer generated Narcotic Report dated 3/24/15, documents 35 residents have physician orders for narcotic medications.

The Facility's Pharmaceutical Procedures policy, dated 2/2013, states, "Medication prescribed for a resident and so labeled shall not be administered to another resident...All mobile medication carts shall be under the visual control of the responsible nurse at all times when not stored safely and securely either in a locked room or otherwise made immobile. The key to the medication cabinet, medication room, or mobile medication cart shall be the responsibility of and in the possession of the person authorized to handle and administer medications...All discontinued, unlabeled, and expired medications shall be returned to the pharmacy for proper disposition and crediting considerations. The only exception shall be controlled drugs, which will be disposed of on premises by two licensed

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145733	A. BUILDING ______ B. WING ______	C 03/31/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JERSEYVILLE MANOR	1251 NORTH STATE STREET JERSEYVILLE, IL 62052

(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) COMPLETION DATE
F 431	Continued From page 13 staff...The Director of Nursing shall provide on-going supervision of personnel administering medication...All discontinued controlled substances will be handled in the following manner: The controlled substances will be destroyed by mixing with an undesirable substance and placed in trash with the assistance of the Director of Nursing or designee and another licensed staff member. Both parties will sign the control sheet as to the destruction and the control sheet will be made part of the resident's permanent record. R3's hydrocodone-acetaminophen 5-325 mg (milligrams) controlled substance record, dated 1/27/15, documents that E14 (Assistant Director of Nursing) and E10 (Licensed Practical Nurse) destroyed R3's hydrocodone-acetaminophen 5-325 mg. R3's controlled substance record, documents that R3 had 13 tablets of hydrocodone- acetaminophen 5-325 mg as of 2/17/15. R3's controlled substance record does not document the number of tablets of hydrocodone-acetaminophen 5-325 mg that were destroyed nor the date of destruction. R3's hydrocodone-acetaminophen 5-325 mg (milligrams) controlled substance record, dated 3/3/15, documents that E14 (Assistant Director of Nursing) and E10 (Licensed Practical Nurse) destroyed R3's hydrocodone-acetaminophen 5-325 mg. R3's controlled substance record, documents that R3 had 30 tablets of hydrocodone- acetaminophen 5-325 mg as of 3/4/15. R3's controlled substance record does not document the number of tablets of hydrocodone-acetaminophen 5-325 mg that were destroyed nor the date of destruction.	F 431		

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F 431	Continued From page 14	F 431		

R16's acetaminophen/codeine #3 controlled substance record, dated 2/28/15, documents that on 3/23/15 one tablet of acetaminophen/codeine #3 was dropped and wasted with one licensed staff member's signature.

R29's hydrocodone-acetaminophen 5-325 mg controlled substance record, dated 2/25/15, documents that on 3/2/15 one tablet of hydrocodone-acetaminophen 5-325 mg and on 3/8/15 two tablets of hydrocodone-acetaminophen 5-325 mg were dropped and wasted with one licensed staff member's signature.

On 3/24/15 at 1:35 p.m., E10 stated, "(E14) would come get our keys to get in to the medication cart, and (E14) would pull out pain pills and ask if I ever administered them. If I said no, (E14) would say I'm going to discontinue the medications and destroy them. I never witnessed (E14) destroy medications. (E14) would say here sign this controlled substance record I'm going to destroy them. (E14) would walk off with the medications in (E14's) hands...Two weekends ago (E14) said (E14) was discontinuing and destroying some resident's narcotics. I signed the controlled substance record, and I asked if (E14) wanted me to witness (E14) destroying the medications and (E14) said no go on to lunch...Then, (E14) showed me a couple pills without counting them, and said I'm going to destroy these...I've seen (E14) getting into other nurse's carts. (E14) got into the 300 Hall cart a lot when I worked that hall."

On 3/25/15 at 2:00 p.m., E3 (Director of Nursing) verified there should always be two nurses when

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F 431	Continued From page 15 destroying medications and this includes dropping/wasting. E3 verified R3, R16, and R29, all had medications wasted/destroyed without being witnessed by two licensed nurses.	F 431		