STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6001531	A. BUILDING: _____ B. WING _____	C 07/01/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOUNT VERNON HEALTH CARE CENTER	#5 DOCTORS PARK MOUNT VERNON, IL 62864

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S 000	Initial Comments Facility Reported Incident of 6/1/2022/IL147805	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.1210b) 300.3210t) 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 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.	S9999	**Attachment A** **Statement of Licensure Violations**	

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S9999	Continued From page 1 Section 300.3210 General t) The facility shall ensure that residents are not subjected to physical, verbal, sexual or psychological abuse, neglect, exploitation, or misappropriation of property. These regualtions were not met as evidenced by: Based on interview and record review, the facility failed to ensure residents were free from misappropriation of controlled substance medications for 2 of 4 residents (R1, R2,) reviewed for misappropriation in a sample of 6. This failure resulted in R2 abruptly missing 8 consecutive doses of her scheduled narcotic pain medication to which a reasonable person would experience increased pain, discomfort and possible opioid withdrawal. The findings include: A facility form titled; "Fax Work Sheet Illinois Department of Public Health (IDPH) Notification Form" documented in part, "On 6/1/2022 (V2, Previous Director of Nursing)/Administrator) discovered that 2 pink narcotic reconciliation sheets for Hydrocodone-Acetaminophen 5-325 tabs for residents (R1) & (R2) were missing from narcotic count book. Upon further investigation the cards containing the medication associated with these pink sheets could not be located in the facility ... Investigation by (V2) on 6/1/2022, (R1) & (R2) both had Norco (Hydrocodone-Acetaminophen 5-325 medications discontinued on 5/30/2022. At that time, it is believed that both residents still had medications in the cart ...This nurse was unsuccessful finding the pink sheets or any empty cards ... (V3	S9999		

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S9999	Continued From page 2 Registered Nurse-RN) phone call with (V2). (V2) asked (V3), "Did you discontinue the Norco on (R1) & (R2) on 5/30/22? Answer: "Yes, I did" V2 asked: "Did you destroy the remaining Norco that were left over?" Answer: "No there was no remaining Norco" V2 stated, "on 5/27/22 (R1) had 30 tabs of Norco delivered, (V3) stated she "was unaware of that delivery." V2 explained that on 5/13/22 (R2) had 120 tabs delivered and that at the time of the discontinued order on 5/30/2022 resident should have had roughly about 52 tabs remaining. (V3) stated "No, I don't think it was there." (V3) also stated "I do not know what happed to it, I think they were both out ...Facility is unable to fully determine what happened to missing pink narcotic sheets & medications but has enough evidence from investigation to support the theory that nurse, (V3) is culpable. Nurse has been relieved of her duties at this facility. IDFPR will be notified of findings." On 6/28/2022 at 10:15 AM, V2 stated, she was notified by V6, Licensed Practical Nurse (LPN) on 5/31/2022 that both (R1) & (R2)'s Hydrocodone-Acetaminophen pain medication was discontinued on 5/30/2022 which was unusual due to (R1) & (R2) both took this frequently for pain. V2 stated, she called (V4) to verify the discontinue orders, and (V4) said she did not give the orders. V2 stated, upon her investigation it was found that (R1) & (R2)'s most recent Hydrocodone-Acetaminophen medication cards and associated narcotic count sheets were not found in the medication cart or logged as destroyed. V2 stated, (V3) did admit to writing both discontinuation orders but denied there was any narcotics in the medication narcotic box for either (R1) or (R2). V2 stated, (V3) was taken off the scheduled pending the investigation, and after completing the nurse interviews she found that	S9999		

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S9999	Continued From page 3 (V3) was culpable for the misappropriation of narcotic medications. V2 stated, (V3) was unable to be reached for termination. On 6/28/2022 at 1:30 PM, V4 (Nurse Practitioner -NP) stated, she did not give (V3) orders to discontinue Hydrocodone-Acetaminophen for either (R1) or (R2) on 5/30/22. V4 also stated, (V3) called her over Memorial holiday and asked for an increase of (R2)'s Hydrocodone -Acetaminophen from 5-325mg to 7.5- 325 mg because (R2) was yelling and in so much pain, and she ordered to use Tylenol as needed between doses of Norco and see how (R2) does. V4 stated, she was suspicious of (V3) calling about narcotics because she was aware of (V3) had a history of drug diversion allegations in another facility she worked at. V4 stated, the next day she received a call from (V3) telling her how well (R2) did with the Tylenol and she did not need the Norco. V4 stated after she was made aware that V3 discontinued the orders for Hydrocodone-Acetaminophen for R1 and R2 , she advised (V2) they would not reorder the hydrocodone-acetaminophen to see how both residents would do without it, and within a few days (V2) called her back and requested to restart hydrocodone-acetaminophen for both (R1) and R2) due to increased pain. V4 stated, she did not think (R1) or (R2) had any negative effects from being off the narcotic medications for the short time because they had regular Tylenol given. On 6/28/2022 at 11:15 AM, V6 Licensed Practical Nurse (LPN) stated, she found telephone orders written by (V3) to discontinue (R1) & (R2)'s hydrocodone-acetaminophen. V6 stated, she found this odd because both residents routinely took the narcotic for pain, and she reported this to	S9999		

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S9999	Continued From page 4	S9999		

(V2) immediately. V6 stated, (V2) could not find (R1) & (R2's) hydrocodone-acetaminophen medication cards, or narcotic count sheets and there was no log of destruction. V6 stated, If the narcotics were discontinued (V3) should have destroyed the narcotics and logged the destruction with another nurse as witness. V6 also stated, it is expected to document narcotics on both the narcotic control sheet and MAR's. V6 also stated, (R1) could ask for pain medication when needed, but (R2) could not ask for her pain medications so they gave (R2)'s on a routine schedule.

6/28/2022 at 2:20 PM, V8 LPN stated, she worked on 5/27/2022 and signed she received (R1)'s pharmacy delivery of Hydrocodone 7.5mg-325mg 30 pills. V8 stated, she took (R1)'s Hydrocodone 7.5mg-325mg 30 tabs to give to (V3) on the same evening and both nurses signed the associated pink narcotic count sheet. V8 LPN stated, (V3) was responsible for putting the medications in the east medication narcotic box and was the primary nurse who worked with (R1) and (R2). V8 also stated, (V2) interviewed and educated nursing to the appropriate administration, and documentation of control medication.

On 6/29/2022 at 9:28 AM & 10:31 AM attempted to reach V3 by phone and was unsuccessful.

1. R2's Face Sheet documents, R2 was admitted to the facility on 1/20/2022 with diagnoses in part of confusion, vascular dementia, with behavioral disturbance, hallucinations at night. R2's Physician's Order Sheet dated from 5-1-2022 to 5-31-2022 documented, Hydrocodone-Acetaminophen 5-325 mg (milligram), take one table by mouth 4 times per

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S9999	Continued From page 5	S9999		

day at 7:00 AM, 11:00 AM, 4:00 PM, and 7:00 PM, start date of 4/15/2022. R2's POS also documented on 5/30/2022, "discontinue (d/c) Norco (Hydrocodone-Acetaminophen) continue with PRN (as needed) Tylenol for pain" ordered by V4 Nurse Practitioner (NP), and order signed taken by V3. This same POS also documents, "Acetaminophen (Tylenol) 500 mg tablet take 2 tablets by mouth every 4 hours as needed for mild pain."

R2's Medication Administration Record (MAR) sheets for 5-1-2022 to 5-31-2022 documented Hydrocodone-Acetaminophen 5-325 mg (milligram) was administered on schedule 4 times a daily at 7:00 AM, 11:00 AM, 4:00 PM, and 7:00 PM. The MAR documented on 5/30/2022 at 7:00 AM and 11:00 AM times were circled which indicated the medication was not given. The Hydrocodone-Acetaminophen was marked through as discontinued on 5/30/2022.

R2's Narcotic Count Sheet and May 2022 MAR sheet had discrepancy for reconciliation of Hydrocodone-Acetaminophen 5-325 mg (milligram). The narcotic was signed given on the MAR sheet 4 times a day from 5/1/2022 to 5/29/2022, and the Narcotic Count Sheet documented narcotic was given up to 5/15/2022. The facility could not produce hydrocodone-acetaminophen narcotic count sheets for the dates of 5/16/2022 to 5/29/2022.

R2's Pharmacy Delivery Sheets dated 5/13/2022 documented, R2 received an amount of 120 tablets of Hydrocodone-Acetaminophen 325 mg. R2's Narcotic Count Sheet associated with this pharmacy delivery sheet was unable to be located by the facility which leaves the 120 Hydrocodone-Acetaminophen 5-325mg

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S9999	Continued From page 6 unaccounted for. R2's Progress Notes dated on 5/31/2022 at 1:00 AM, and 5/31/2022 at 4:30 AM documented in part, (R2) was yelling out frequently. On 6/30/2022 at 1:37 PM, V11 (Medical Doctor -MD) stated, he was made aware of the misappropriation incident of 6/1/2022. V11 stated, he did not think abruptly stopping (R2)'s narcotic medication given 4 times a day would be harmful as long as the nursing staff closely monitored vital signs and signs and symptoms of pain. On 7/1/2022 at 11:06 AM, V2 stated, she thinks (R2) was getting regular Tylenol as needed during the time she was off the scheduled Hydrocodone Acetaminophen 5-325mg based on (R2)'s pain management flow sheets documented pain medication was given as an intervention, but they failed to document it on the PRN MAR. V2 also stated, she has since educated the nurses to document all medications administration including PRN's medications accurately to account for medication administration. R2's PRN Medication record for May 2022 does not document R2 received PRN Tylenol on either 5/30/22 or 5/31/22 for pain. 2. R1's Face Sheet documents R1 was admitted to facility with diagnosis of Hypertension, Depression, Acid Reflux, Hyperlipidemia, Dementia, Irritable Bowel Syndrome, Arthritis, Insomnia, Macular Degeneration, and Chronic Obstructive Pulmonary Disease. R1's Physician's Order Sheet (POS) dated 5-1-2022 to 5-31-2022 documented an order for PRN (as needed) Hydrocodone-Acetaminophen 7.5-325 mg (milligram), take one table by mouth every 6	S9999		

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S9999	Continued From page 7 hours as needed for pain, start date on 04/15/2022. R1's POS also documented on 5/30/2022, "discontinue (d/c) Norco (Hydrocodone-Acetaminophen) continue with scheduled Tylenol" ordered by (V4) and signed by (V3). R1's PRN Medication Administration Record (MAR) dated 5-1-22 to 5-31-22 documented Hydrocodone-Acetaminophen 7.5-325 mg (milligram) was administered on the following dates; 5/1/2022 at 1:30 PM, 5/7/2022 at 7:39 PM, 5/11/2022 at 4:50 AM, 5/12/2022 at 11:00 AM, 5/15/2022 at 12:30 AM, 5/16/2022 at 6:25 PM, 5/21/2022 at 2:00 PM, 5/23/2022 at 12:00 AM, 5/24/2022 at 11:45 AM, 5/25/2022 at 12:25 AM, 5/26/2022 at 2:45 AM, 5/26/2022 at 10:50 PM. R1's PRN MAR documented Hydrocodone-Acetaminophen 7.5-325 mg was discontinued on 5/30/2022. R1's Narcotic Count Sheet with a delivery date of 4/25/2022, documented an amount of 30 Hydrocodone-Acetaminophen 7.5-325 mg tabs. The same narcotic count sheet documented in part, the narcotic was administered on 5/1/2022 at 0700 AM, 5/1/2022 at 1230 PM, 5/1/2022 at 6:00 PM, 5/2/2022 at 7:00 AM, 5/2/2022 at 2:30 PM, 5/2/2022 at 7:40 PM, 5/3/2022 at 7:00 AM, 5/3/2022 at 12:00 PM, 5/3/2022 at 6:00 PM, 5/4/2022 at 7:00 AM, 5/5/2022 at 6:30 AM, 5/5/2022 at 11:45 AM, 5/5/2022 at 5:15 PM, and 5/5/2022 at 11:00 PM. The same Narcotic Count Sheet and May 2022 MAR sheet had discrepancy for reconciliation of narcotic administration for the dates of 5/7/2022, 5/11/2022, 5/12/2022, 5/15/22, 5/16/22, 5/21/2022, 5/23/2022, 5/24/2022, and 5/25/2022. The facility was unable to produce R1's narcotic count sheets for Hydrocodone-Acetaminophen 7.5mg-325 mg	S9999		

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S9999	Continued From page 8 administered from dates 5/7/2022 to 5/25/2022. R1's undated Narcotic Count Sheet, documented, "Hydrocodone-Acetaminophen 7.5-325 mg every 6 hours as needed, an amount of 4 tabs documented, Hydrocodone-Acetaminophen 7.5-325 mg was administered on 5/26/2022 at 2:45 AM, 5/26/2022 at 9:00 AM, 5/26/2022 at 2:30 PM, and 5/26/2022 at 10:50 PM. The same Narcotic Count Sheet and May 2022 MAR sheet had discrepancy for reconciliation of narcotic administration for the dates for 5/26/2022 at 9:00 AM, and 5/26/2022 at 2:30 PM. A Pharmacy delivery sheet dated 5/27/2022 documented, R1 received 30 Hydrocodone-Acetaminophen 7.5-325 mg tablets. R1's Narcotic Count Sheet associated with this pharmacy delivery were unable to be located by the facility which leaves 30 Hydrocodone-Acetaminophen 7.5 mg-325 mg tablets unaccounted for. A facility policy titled, "Abuse Prevention Program, dated revised on 11/28/2216 documents the following in part - "Policy, This facility affirms the right of our residents to be free from abuse, neglect, misappropriation of resident property ...The Purpose of this policy is to ensure that the facility is doing all that is within its control to prevent occurrences of mistreatment, exploitation, neglect or abuse of our residents ...Definitions: Misappropriation of resident property means the deliberate misplacement, exploitation, or wrongful, temporary, or permanent use of resident's belonging or money without the resident's consent." Facility Policy entitled, "Medication Administration" date revised on 11/18/2017,	S9999		

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S9999	Continued From page 9 documented in part, 19. Document any medications not administered for any reason by circling initials and documenting on the back of the MAR the date, the time, the medication and dosage, reason for omission and initials." The Center for Disease (CDC) Guide for Clinicians on the Appropriate Dosage Reduction or Discontinuation of Long-Term Opioid Analgesics, dated October 2019, documented in part, "This HHS Guide for Clinicians on the Appropriate Dosage Reduction or Discontinuation of Long-Term Opioid Analgesics provides advice to clinicians who are contemplating or initiating a reduction in opioid dosage or discontinuation of long-term opioid therapy for chronic pain. In each case the clinician should review the risks and benefits of the current therapy with the patient and decide if tapering is appropriate based on individual circumstances."...Risks of rapid opioid taper 1. Opioids should not be tapered rapidly or discontinued suddenly due to the risks of significant opioid withdrawal... (B)	S9999		