

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  145341	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  07/24/2024
NAME OF PROVIDER OR SUPPLIER  Encore Village		STREET ADDRESS, CITY, STATE, ZIP CODE  350 West Schaumburg Road Schaumburg, IL 60194	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0602</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Protect each resident from the wrongful use of the resident's belongings or money.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 34314</p> <p>Based on observation, interview and record review the facility failed to protect a resident's right to be free from misappropriation of resident property. This applies to 1 of 4 residents (R1) reviewed for misappropriation in the sample of 8.</p> <p>The findings include:</p> <p>R1's face sheet list her diagnoses to include: urine retention, urinary tract infection, atrial fibrillation, heart failure, unilateral primary osteoarthritis of the left knee, morbid obesity, anxiety, osteoarthritis, muscle weakness and a history of malignant neoplasm of the breast.</p> <p>On July 24, 2024 at 8:45 AM, R1 was lying in bed watching television. She stated, she stole 30 of my pills. She stated, she told him (V5 Unit Manager) she (R1) was feeling dizzy but she never said that. The facility did call the police and they came and talked with her and her daughter. She stated, she didn't know her name but she was chubby and had curly hair.</p> <p>(continued on next page)</p>

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.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0602</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>The facility's final incident report dated July 22, 2024 shows, Resident Name: (R1). Date of incident: 7/18/2024. Incident category: resident misappropriation of property/theft. Summary of incident: On 7/18/2024 the nurse manager (V5 Unit Manager) reported that the resident's Norco (pain medication) 7.5/325 mg (milligram) 30 tablets were missing. The Norco was delivered on 7/16/2024 in a bingo card [sic] with 30 tablets Based on investigation, on 7/17/2024 approximately 4:00 PM, resident (R1) was complaining of pain to her left knee and was asking if she can take Norco. The PM agency nurse on duty was not able to find Norco in narcotic box. The NP (Nurse Practitioner) was noted to have written a new script of Norco on 7/15/2024. The pharmacy reported that the Norco was delivered on 7/16/2024 early AM delivery and was received by the night nurse. The PM nurse on duty reported to the nurse manager that she cannot locate the Norco that was delivered early that day . On 7/17/2024, the AM nurse (V4 LPN/Licensed Practical Nurse) was interviewed and stated initially that the resident complained of feeling dizzy with the Norco and she notified the doctor about the resident's complaint and received an order for Tramadol (pain medication). Nurse Manager (V5 Unit Manager) reached out to the doctor for the Tramadol order, but the doctor stated she did not receive any phone call from the AM nurse (V4 LPN). The Nurse Manager (V5 Unit Manager) called (V4 LPN) back and let her know that the doctor was stating that she did not receive any phone call from (V4 LPN) and there was no order of Tramadol in PCC (a computer program used for electronic charting). The nurse manager (V5 Unit Manager) explained to (V4 LPN) that she needs to be honest and explained what happened to the Norco because we are going to notify the Police and (State Agency). (V4 LPN) sent an email to the Nurse Manager (V5 Unit Manager) that night stating she admitted to taking the Norco home with her because she has been having a hard time and has no insurance to pay for her medication</p> <p>On July 24, 2024 at 9:10 AM, V5 (Unit Manager) stated, the PM nurse came to him and reported that R1 was asking for pain medication and she couldn't find it. He checked the computer and seen the medication was discontinued by V4 (LPN). He called V4 (LPN) and asked what happened. V4 (LPN) told him the medication was discontinued because the resident said she was feeling dizzy from the Norco. V4 (LPN) called the doctor and explained what R1 said. The doctor discontinued the medication and prescribed Tramadol instead. V5 (Unit Manager) tried to verify that this was the correct story and the called the doctor. The doctor denied that she had discontinued the medication or that V4 (LPN) had called her. R1 also denied feeling dizzy and/or requesting to take the medication. V5 (Unit Manager) called V4 (LPN) back and told her that she needed to tell him what happened to the Norco. He stated, V4 (LPN) denied taking it at first but then started to cry saying she didn't have insurance or any money. He told her that she needed to send him an email stating the information she told him because she had already told him a bunch of lies. He received an email from V4 (LPN) later that night. He also stated, V4 (LPN) brought back the narcotic count sheet the next day (July 18, 2024) but did not bring back any Norco tablets. V4 (LPN) took the entire Norco bingo card [sic] of 30 tablets.</p> <p>The facility provided email from V4 (LPN) to V5 (Unit Manager) dated July 17, 2024 shows, On 7/16/2024. I work 6:30 AM to 3 PM shift. I did mistake that day because I am struggling right now financial situation and the health problem this was my first mistake. I tried to lie, but I can't because I'm not that kind of person it just my problem make me do that. I took patient Norco with me because I don't have money to buy and I don't have insurance. I apologize this was my big mistake so please forgive me for my mistake .</p> <p>R1's July Medication Administration Record shows, an order for hydrocodone-acetaminophen (Norco) oral tablet 7.5-325 mg, give 1 tablet by mouth every 4 hours as needed for pain level 6-10.</p> <p>(continued on next page)</p>		

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<p>F 0602</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>The pharmacy requisition form provided by the facility on July 24, 2024 shows, 30 tablets of hydrocodone-acetaminophen tablets 7.5-325 mg was delivered on July 16, 2024. V4 (LPN) took the medication the day it was delivered so the PM nurse coming after her did not know that 30 tablets were delivered earlier that day.</p> <p>R1's discontinue order for hydrocodone-acetaminophen oral tablets was discontinued on July 16, 2024 by V4 (LPN).</p> <p>R1's Minimum Data Set, dated dated dated [DATE] shows, she is cognitively intact.</p> <p>The facility's Abuse, Neglect, Exploitation and Misappropriation Prevention Program dated April 2021 shows, Policy Statement: Residents have the right to be free from abuse, neglect, misappropriation of resident property and exploitation. Policy Interpretation and Implementation: The resident abuse, neglect and exploitation prevention program consists of a facility-wide commitment and resource allocation to support the following objectives: 1. Protect residents from abuse, neglect, exploitation or misappropriation of property by anyone including, but not necessarily limited to: a. facility staff .</p>		