

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  145785	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  06/08/2025
NAME OF PROVIDER OR SUPPLIER  Nexus at Mascoutah		STREET ADDRESS, CITY, STATE, ZIP CODE  901 North Tenth Street Mascoutah, IL 62258	

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> Based on observation, interview and record review the facility failed to prevent an employee from misappropriating narcotic pain medication for 2 of 3 residents (R2, R3) reviewed for misappropriation of property in a sample of 3.</p> <p>Findings include:</p> <p>1. R2's Undated Face Sheet documents she was initially admitted to the facility on [DATE] with diagnosis of pain and GERD.</p> <p>R2's Undated Care Plan, documents chronic pain related to GERD and chronic knee pain.</p> <p>R2's Physician's Order Sheet (POS) dated 4/2025 and 5/2025 documents a physician's order, start date of 7/14/2024, hydrocodone-acetaminophen 5-325 milligrams (mg) give 2 tablets by mouth every 4 hours as needed for pain.</p> <p>R2's Minimum Data Set (MDS) dated [DATE] documents resident is cognitively impaired and has occasional pain.</p> <p>R2's Controlled Drug Received Record/Disposition Form, received from the pharmacy on 7/26/2024 documents V4, Licensed Practical Nurse, LPN, signed off she administered hydrocodone 5-325 mg to R2 on 4/17/2025, 4/22/2025, 4/27/2025, 4/28/2025, 5/1/1025 2 doses, 5/2/2025, 5/3/2025, 5/5/2025 and 5/6/2025 that equals 20 pills administered.</p> <p>R2's Controlled Drug Received Record/Disposition Form, received from the pharmacy on 4/23/2025 documents V4 signed off she administered hydrocodone 5-325 mg to R2 on 5/1/2025, 5/6/2025 2 doses, 5/7/2025, 5/9/2025, 5/10/2025 3 doses, 5/11/2025 3 doses, and 5/12/2025 2 doses that equals 26 pills administered.</p> <p>R2's MAR dated 4/2025 documents V4 signed off hydrocodone 5-325 mg was administered to R2 on 4/22/2025 or 4/28/2025 which equals 4 pills administered. V4 signed off 6 pills administered on R2's narcotic count sheet for 4/2025.</p> <p>R2's MAR dated 5/2025 documents V4 signed off hydrocodone 5-325 mg was administered on 5/9/2025, 5/11/2025, 5/15/2025, 5/20/2025 and 5/31/2025 which equals 10 pills administered. V4 signed off 26 pills on 5/2025 on R2's narcotic sheet.</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>On 6/3/2025 at 5:00 PM V1, Administrator stated she was first alerted by V2, Director of Nursing, DON about suspicious documentation on R2's hydrocodone 5-325 mg narcotic count sheet on 5/21/2025. V1 stated she, V2 and V3, Assistant Director of Nursing, ADON went over all narcotic count sheets at that time and noted that V4, LPN was assigned to R2 and R3 on a regular basis and was signing off on the narcotic count sheets both hydrocodone 5-325 mg tablets were being administered to both residents PRN (as needed) as soon as the medications were available. V1 stated neither R2 nor R3 have a history of taking hydrocodone on a regular basis and they are both prescribed PRN. V1 stated both R2 and R3 aren't interviewable and she believes that is why V4 targeted their hydrocodone because they couldn't speak for themselves. V1 stated V4 didn't sign the hydrocodone off on either R2's or R3's MAR, just on the narcotic sheets. V1 stated she called V4 into the facility to be interviewed. V1 stated V2 and V3 and the police were called. V1 stated V4 confessed to the police that she took R2's and R3's hydrocodone 5-325 mg tablets and had taken 66 pills total. V1 stated V4 was hired as an LPN to the facility and worked night shift 6:00 PM to 6:00 AM and worked full time since her hire date of 4/2/2025. The first time V4 signed off hydrocodone on R2's narcotic count sheet was 4/17/2025 and it was brought to her attention on 5/21/2025. V4 told her that she got the hydrocodone medication from the medication cart, signed it off on the resident's narcotic count sheet then went to the resident's room and placed the pill in her pocket to take it later. V1 stated there was no video evidence of V4 taking the narcotic pain medication by mouth or putting it in her pocket because she allegedly did that in resident rooms, where there are no surveillance cameras. V1 stated the facility has done several audits of the narcotics since this has been brought to her attention and no further issues with narcotics were discovered. V1 stated V4 was terminated the same day the investigation was initiated on 5/21/2025 so she no longer has access to the resident's narcotic pain medication at the facility.</p> <p>On 6/3/2025 at 5:20 PM V3, Assistant Director of Nurses (ADON) stated V5, Registered Nurse, RN, stated she was aware of suspicious documentation on R2's and R3's hydrocodone 5-325 mg PRN narcotic count sheets on 5/21/2025 and she worked with V1 and V2 to get the investigation started. V3 stated she and V2 interviewed V4 at the facility and she initially stated it was a mistake and that she read the resident's hydrocodone physician order wrong, she thought it was scheduled, not PRN then she changed her story to it was just a mistake then she spoke 1:1 to the local police officer at the facility and she confessed to stealing R2's and R3's hydrocodone 5-325 mg pills and it was 66 pills she stole in total. V3 stated V4 told her she was in pain and the hydrocodone helped her get through the day. V4 told her she walked into the resident's room as if she was going to administer the hydrocodone medication then she put it in her pocket. V3 didn't know if V4 took the hydrocodone pain medication while working or not. V3 stated she worked with V4 on night shift a few times and never noted her to be under the influence or off in any way.</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>On 6/3/2025 at 5:45 PM V2, Director of Nurses (DON) stated she and V3 were notified by V5 of suspicious documentation on (R2's) narcotic count sheet on 5/21/2025. V2 stated her and V3 did a complete audit on all resident's narcotic count sheet and noted suspicious documentation on R3's narcotic count sheet as well. Neither R2 nor R3 took the hydrocodone PRN medication often but according to the narcotic count sheet something had occurred because V4 documented both residents were taking the narcotic pain medication multiple times a shift when V4 worked. V2 stated it was odd and she knew something was really wrong when she checked R2's and R3's MARs, V4 didn't document on the resident's MAR that the medication was administered. V2 stated no resident's narcotic count sheets count was off at anytime. V2 stated it was only because V5 brought it to her attention that the facility caught onto what V4 was doing which was stealing R2's and R3's hydrocodone PRN narcotic pain medication. V2 stated she and V3 interviewed V4 the same day and she initially denied taking any residents hydrocodone narcotic pain medication, then the police got here, and she spoke to the police officer 1:1 and admitted to stealing 66 pills of R2's and R3's hydrocodone 5-325 mg PRN pills.</p> <p>On 6/3/2025 at 6:05 PM V5, RN stated she works days from 6:00 AM to 6:00 PM. V5 stated was the nurse to initially find the suspicious documentation on R2's narcotic count sheet on 5/21/2025. V5 stated as soon as V2 got to the facility she gave her R2's narcotic count sheet and said something is suspicious here and V2 told her she'd look into it. V5 stated she knew something wasn't right because R2 rarely takes Tylenol and never requests a narcotic pain medication from her and when she saw R2's hydrocodone 5-325 mg PRN pill count went from 20 pills for the longest time down to 6 pills she knew there was an issue. V5 stated V4 probably took the narcotic pain medication from R2 and R3 because neither one of these residents are interviewable and they couldn't speak up and tell on her for taking their medications.</p> <p>On 6/3/2025 at 7:05 PM V4, LPN stated she started working at the facility as an LPN on 4/2/2025 and she has chronic bilateral hip pain which she used to get pain injections for, but she no longer has health insurance so when she started working at the facility, she was tempted to take R2's and R3's hydrocodone 5-325 mg PRN narcotic pain medication because she was hurting really bad. V4 stated she documented the hydrocodone was administered on the narcotic count sheet but not on the resident's MAR and that's how she got caught. On 5/21/2025 she was sleeping and V2 called her to come in and speak to about a concern. V4 stated when she got to the facility, she spoke to V2 and V3 about the documentation on R2's and R3's hydrocodone narcotic count sheets and initially V4 stated she denied taking the resident's hydrocodone pills but then she spoke to the police officer at the facility, and she finally admitted to it. V4 stated she took approximately 11 to 14 hydrocodone 5-325 mg PRN pills from R2 and R3 hydrocodone 5-325 mg PRN pills from R3. V4 stated she didn't take anywhere close to 66 hydrocodone 5-325 mg pills from the residents. V4 stated she knew what she did was wrong, but she was in such pain she felt she didn't have another choice. V4 stated she didn't take the resident's hydrocodone pills at the facility she entered the resident's room as if she was going to administer the medication then she put the pill in her pocket and took it so she could sleep when she got home from work.</p> <p>(continued on next page)</p>		

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