Printed: 09/27/2024
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145886	A. Building B. Wing	05/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Aledo Rehab & Health Care Center	304 S.W. 12th Street Aledo, IL 61231

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)
F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from the wrongful use of the resident's belongings or money. 30899 Based on observation, interview, and record review the facility failed to prevent misappropriation of narcotic medication for one resident (R1) of three residents reviewed for controlled medications. Findings include: Facility Policy/Abuse Prevention Program dated 11/28/2016 documents: This facility affirms the right of our residents to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined below. Misappropriation of Property is the deliberate misplacement, exploitation, or wrongful temporary or permanent use of residents' belongings or money without resident consent. Missing Controlled Substance-Investigation Worksheet indicates on 4/25/24 at 6:00am one dose of R1's Hydrocodone-Acetaminophen (narcotic) 5-325mg (milligram) was missing. On 5/8/24 at 1:45pm V9, DON (Director of Nursing) stated that V3, RN (Registered Nurse) went to the hospital (on 4/24/24) at 8:30pm and was found to have been impaired so V4, RN was called to come in early to replace V3. V9 stated the police arrived to the facility at approximately 1:30am after being notified that V3 was under the influence of methamphetamines. V9 stated I was called after the police arrived by (V4) and was told the (controlled) medication count was off by one tab. The missing tablet belonged to (R1). V9 stated (V4) and I counted after the Police, and I corrected the Control Sheet for the missing tablet. Now we haven't been able to find that control sheet. Were still looking. It was one tab of Hydrocodone for (R1). (continued on next page)

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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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/9/22 at 6:25pm V4, RN stated that V9, DON was the nurse who briefly took over when V3 was taken to the hospital. V4 stated he arrived at the facility about 5:30pm on 4/24/24 and V9 immediately left. V4 stated that he could not recall if he counted the controlled medications with V9 at that time. V4 stated that after V9 left, he went back to the Memory Care and did a self-count of the controlled medications because there was no other nurse to count with in the building and that's when he initially found the controlled medication count was not accurate. V4 stated he did not notify V9, DON of the missing Hydrocodone at that time. V4 stated When the Police arrived about 1 or 2am I immediately told them one tablet of Hydrocodone was missing and then called V9 to report that the controlled medication count was off. I didn't sign the controlled medication use sheet until the next day when I counted with (V9). On 5/10/24 at 2pm V9, DON stated When (V4) and I counted (on 4/25/24) there were only two Hydrocodone tablets for (R1) and the control sheet indicated there should be three tablets. We still can't find the control sheet and we can't determine who administered one of the two tablets left on the card. We only have a record of one tablet documented as administered on 4/30/24, so actually two of (R1's) Hydrocodone tablets cannot be accounted for.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. 30899 Based on observation, interview, and record review the facility failed to ensure an accurate shift-to-shift controlled medication inventory count, failed to ensure refrigerated controlled medications were immediately double locked, and failed to ensure controlled medication tracking sheets had accurate reconciliation. This failure has the potential to affect all 16 residents (R1 - R15) who have physician orders to receive controlled medications. Findings include: Facility Policy/Missing Controlled Substance dated 2010 documents: It is the policy of this facility to prevent the loss of controlled substances and vigorously investigate incorrect inventory of controlled drugs, medications or pharmaceuticals reported by pharmacists, physicians or licensed nurses. All controlled drugs will be counted by the oncoming and outgoing nurse at the change of each shift as per the Controlled Drug Policy and Procedure. The count of each controlled medication will be maintained on the drug disposition sheet for each individual medication as per the Controlled Substance Policy. The oncoming and outgoing Licensed Nurse will sign the controlled substance inventory sheet each change of shift to signify the count was complete and is accurate. Facility Policy/Controlled Substances dated 2006 documents: Schedule II drugs are to be kept under two separate locks requiring two separate keys. The drugs in other schedules deemed necessary for control are placed under the same restrictions as Schedule II drugs by the pharmacist. The drugs in Schedule II (and those in other schedules which have been restricted and stored in the Controlled Substance cabinet) will be counted and reconciled by the nurse coming on duty with the nurse going off duty. These records shall be retained for one year. Pharmacy Resident Roster dated 5/9/24 indicates 16 residents in the facility have orders for Controlled Substances (medications). Missing Controlled Substance-Investigation Worksheet indicates on 4/25/24 at 6:00am one dose of R1's Hydrocodone-Acetaminophen (narcotic) 5-325mg (milligram) was missing. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 5/8/24 at 1:45pm V9, DON (Director of Nursing) stated that V3, RN (Registered Nurse) went to the hospital (on 4/24/24) at 8:30pm and was found to have been impaired so V4, RN was called to come in early to replace V3. V9 stated the police arrived at the facility at approximately 1:30am after being notified that V3 was under the influence of methamphetamines. V9 stated I was called after the police arrived by (V4) and was told the (controlled) medication count was off by one tab. The missing tablet belonged to (R1). V9 stated (V4) and I counted after the Police, and I corrected the Control Sheet for the missing tablet. Now we haven't been able to find that control sheet. Were still looking. It was one tab of Hydrocodone for (R1). On 5/9/22 at 6:25pm V4, RN stated that V9, DON was the nurse who briefly took over when V3 was taken to the hospital. V4 stated he arrived at the facility about 5:30pm on 4/24/24 and V9 immediately left. V4 stated that he could not recall if he counted the controlled medications with V9 at that time. V4 stated that after V9 left, he went back to the Memory Care and did a self-count of the controlled medications because there was no other nurse to count with in the building and that's when he initially found the controlled medication count was not accurate. V4 stated he did not notify V9, DON of the missing Hydrocodone at that time. V4 stated When the Police arrived about 1 or 2am I immediately told them one tablet of Hydrocodone was missing and then called V9 to report that the controlled medication count was off. I didn't sign the controlled medication use sheet until the next day when I counted with (V9). On 5/10/24 at 2pm V9, DON stated When (V4) and I counted (on 4/25/24) there were only two Hydrocodone tablets for (R1) and the control sheet indicated there should be three tablets. We still can't find the control sheet and we can't determine who administered one of the two tablets left on the card. We only have a record of one tablet documented as administered on 4/30/24, so actually two of (R1's) Hydrocodone tablets cannot be accounted for. Shift Change Accountability Record Sheet for Controlled Substances indicate All narcotics are to be counted by two licensed nurses at the end of each shift. If a discrepancy noted in the actual count, you must notify the DON and the Administrator prior to leaving your shift. Make sure you sign off in the correct area to verify the count was completed by on-coming nurse and the nurse leaving. Shift Change Accountability Record Sheet for Controlled Substances for both medication carts reviewed on 5/8/24 found incomplete signature documentation for on-coming and off-going nurses from 3/1/24 through 5/8/24. 2) On 5/8/24 at 11:15am Medication Room medication refrigerator on the Memory Care Unit, had one full/unopened bottle of Lorazepam (schedule IV antianxiety/controlled substance that should be stored under two separate locks requiring two separate keys) for R1. The refrigerator within the medication room was unlocked. At that time, V7, RN stated I've been here since December (2023), it's never been locked. I never saw a lock and I didn't know those meds should be double locked. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3) On 5/8/24 at 11:25am in the locked box within the medication cart on the Memory Care Unit, a bottle of Morphine (opiate) - with the plastic wrapper still in place over the lid and neck of the bottle - was in a plastic bag within the locked box. The bottle of Morphine was leaking and some of the medication contents were visible through the plastic bag and had completely soaked through the label of the medication attached to the bottle. Upon withdrawing the bottle from the plastic bag, the bottle was wet with Morphine and coated the entire label, bottle and inside of the clear plastic bag. Upon closer inspection of the wrapper covering the bottle, it was observed that the entire cap of the bottle could be removed without removing the plastic wrapper that would usually be necessary to remove the cap from an unopened bottle of medication. At that time V7, RN stated That bottle has been like that for a while. V7 also acknowledged it was impossible to do an accurate accounting of the medication amount due to the on-going leaking. V2, (Regional Nurse Consultant) assisted with measuring the amount left in the leaking bottle of Morphine by removing the entire cap and pouring the contents into a medication cup which then totaled 24ml (milliliters) of Morphine. With difficulty due to the wet label, there was enough visible identification on the label to determine the bottle of Morphine belonged to R1 and the Rx # matched the number on the Controlled Substances Proof of Use form that indicated the amount in the bottle of Morphine was 30ml and received from the pharmacy on 10/9/23. No correction to the amount of leaked Morphine was documented on the form. At that time V2, RNC stated the leaking bottle of Morphine should have been reported to the pharmacy and/or identified as unable to determine amount of leakage. A separate Controlled Substances Proof of Use form indicated the facility received 30ml of liquid Lorazepam (antianxiety) from the pharmacy on 10/4/23. Form indicates that on 3/25/24 Count corrected bottle leaking, 28ml remaining. On 5/8/24 at 11:30am V7, RN stated she thought the leaking bottle of Morphine went with the Lorazepam Controlled Substances Proof of Use Form since the label on the bottle was difficult to read and just assumed they went together. On 5/10/24 at 3:00pm V11, Certified Pharmacist Technician stated that if the bottle of liquid Morphine was leaking when it was delivered, the facility should have refused delivery and sent it back to the pharmacy. V11 stated if it started leaking after it was accepted by facility staff, the staff should destroy the medication as it could have been tampered with since the plastic wrapper was still intact. V11 stated it is the facility's responsibility to keep track of the control sheets.