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
	145920	A. Building B. Wing	07/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Allure of Prophetstown	310 Mosher Drive Prophetstown, IL 61277

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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31615 Based on observation, interview and record review the facility failed to ensure a master count of controlled substances was maintained. This failure resulted in a resident's controlled medication to be missing for 1 of 3 residents (R1) reviewed for controlled medication counts. This past non-compliance occurred form 7/13/24 to 7/18/24. The findings include: R1's admission record shows she was admitted to the facility on [DATE] with multiple diagnoses including other chronic pain, and fibromyalgia. The 7/31/24 order summary sheet for R1 shows an order for hydrocodone-acetaminophen tablet 5-325 mg (Norco) , 1 tablet to be given every morning and at bedtime for pain. R1's progress notes show on 7/11/24 at 4:00 PM, she was sent out and admitted to the hospital and returned on 7/15/24 at 4:00 PM. On 7/31/24 at 10:50 AM, V4 LPN (Licensed Practical Nurse) said on 7/11/24 she gave R1 her morning dose of Norco and then later in the shift, sent her out to the hospital. The Norco was in the cart at the end of the shift count. She said when R1 returned from the hospital on 7/15/24, she noted the Norco missing from the medication cart. V4 said she was not sure what had happened to it, and followed up on 7/16/24 with the pharmacy and the DON (Director of Nursing) to see if the completed narcotic sheet had been turned into her. She said once she reported it, the medication room was searched and both medication carts and the Norco was no where to be found. She reported the missing medication to the administrator. V4 said, at the time of the missing Norco, there was no master count of the narcotics and the only way to know if a medication was missing would be the nurses knowing what should be in there. On 7/31/24 at 10:33 AM, V6 RN (Registered Nurse) said she worked on 7/11/24 and had punched out R1's medications on accident, after realizing R1 was in the hospital. She wasted the Norco with the other nurse on duty, so she knows the card was present and accounted for during her shift and reporting off on 7/12/24 at 6:00 AM. (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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NAME OF PROVIDER OR SUPPLIER: Allure of Prophetstown		STREET ADDRESS, CITY, STATE, ZIP CODE: 310 Mosher Drive, Prophetstown, IL 61277	

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(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	On 7/31/24 at 9:45 AM, V5 RN said R1 was on a scheduled Norco twice daily and should have had a card in the cart. V5 said R1 went to the hospital on 7/11/24 and was not working that day, but did notice on the narcotic count on 7/13/24, R1's Norco was not in the drawer. V5 said she asked V3 RN during the count about R1's card and she did not have any answer. V5 said V3 was an agency nurse and was not familiar with her. She noticed the Norco was gone along with the count sheet. V5 said R1 remained in the hospital, so she continued the count. When R1 returned on 7/15/24, there still was no Norco tablets. On 7/31/24 at 11:00 AM, V1 Administrator said it was reported to her R1 was missing Norco tablets. She said both medication carts and the medication room, and the pills were no where to be found. She said the pharmacy was contacted and it was determined R1 should have had about 10 pills left in her card. On 7/31/24 at 11:17 AM, V3 RN said she worked the night shift on 7/12/24 into the morning of 7/13/24. She said it was only her second time in the facility. She said the narcotic count was completed at the beginning of her shift. She did not recall giving any Norco during her shift, and did not recall seeing a card of Norco for R1. V3 said the facility had no master count on the cart, the total number of controlled substances on the medication cart. She said R1 was not in the facility during her shift. The facility's incident report details security camera footage on 7/12/24 at 6:23 PM, V4 counted narcotics with V3, and 15 pages were turned in the count book. On 7/13/24 at 6:22 AM, V3 counted narcotics with V5, and only 14 pages were turned in the book. On 7/31/24 at 11:00 AM, V1 said through her interviews and watching the camera footage she believed V3 took the Norco card and the count sheet. The facility's 2024 policy for compliance with reporting allegations of abuse/neglect/exploitation documents 4. Identification: The facility will identify events, occurrences, patterns and trends that may constitute: c. Misappropriation of Resident Property: The deliberate misplacement, exploitation, or wrongful, temporary or permanent, use of a resident's belongings or money without the resident's consent. Prior to the survey date of 7/31/24, the facility had taken the following actions to correct the noncompliance: 1. On 7/18/24 the facility implemented a new master count procedure for controlled substances, with daily QA audits conducted by the DON for compliance for all medication carts. 2. On 7/18/24 all nurses were educated on the master count policy and procedure. The Medication Administration policy was updated. 3. On 7/18/24, Nurses, CNA's (Certified Nursing Assistants) were educated on Abuse, Neglect, and exploitation.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31615 Based on observation, interview and record review the facility failed to document the administration of controlled medications for 1 of 3 residents (R3) reviewed for controlled medication in the sample of 3. The findings include: R3's admission record shows she was admitted to the facility on [DATE] with multiple diagnoses including dementia, Alzheimer's disease, and primary generalized osteoarthritis. On 3/12/24 a diagnosis of a fracture of the right femur was added. R1's order summary sheet shows a 3/12/24 order for one Norco tablet 5-325 mg to be given by mouth every 6 hours as needed for pain. R1's June 2024 MAR (Medication Administration Record) shows V9 LPN (Licensed Practical Nurse) gave one dose of Norco on 6/15/24 at 8:34 PM. No other doses were documented on the MAR. The controlled drug receipt record/disposition form documents between 6/1/24 and 6/26/24, a total of 9 pills were signed out by V9, with 8 doses not signed on the MAR. R1's July 2024 MAR shows only one doses given during the month on 7/21/24 at 2:32 AM. V9 documents the dose given as effective. No other doses were documented. The controlled drug receipt record/disposition form shows from 7/3/24 to 7/29/24, a total of 9 pills were signed out by V9 with only 1 dose documented. On 7/31/24 at 1:06 PM, V2 DON (Director of Nursing) said when a nurse is passing medications each pill should be documented after it is given. She said if the medication is a PRN (as needed) medication, the nurse should follow up to ensure it was effective and document the result on the MAR. On 7/31/24 at 1:25 PM, V9 said she gives R3 her Norco for complaints of back pain, knee pain and abdominal pain. She said R3 had hip surgery a few months ago. V9 said R3 is unable to assess her pain by a scale due to confusion. She said when giving a controlled medication is should be signed out, and documented on the MAR when given. She had no reason why she was not documenting the medication, just forgetting to do it. She said all of the doses signed out were given to R3. On 7/31/24 at 1:18 PM, R3 was observed sitting up in her wheelchair visiting with V10 (husband) in her room. She was alert, but unable to state where she had pain, or if she received pain medications at night. She said the nurse just knows to bring the medication to her. V3 was rubbing the tops of her thighs and looking at her feet. V10 stated (R3) had a recent fracture of her hip and probably takes the pain medications to help her sleep. The facility's 2024 policy for medication administration notes Medications ar administered by licensed nurses, or other staff who are legally authorized to do so in this state. Policy Explanation and compliance guidelines: 20. Sign MAR after administered.