

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 146023	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/20/2024
NAME OF PROVIDER OR SUPPLIER Arthur Home, The		STREET ADDRESS, CITY, STATE, ZIP CODE 423 Eberhardt Drive Arthur, IL 61911	

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>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31642</p> <p>Based on record review and interview the facility failed to protect residents' right to be free from misappropriation of narcotic medication, for two of seven resident (R1 and R2) reviewed for misappropriation on the sample list of seven.</p> <p>Findings include:</p> <p>1.) R1's Continuity of Care electronic medical record dated 3/6/24 documents the following diagnoses: Age-related Osteoporosis without Current Pathological Fracture, Displaced Fracture of Posterior Wall of Left Acetabulum, Subsequent Encounter for Fracture With Routine Healing, Unilateral Primary Osteoarthritis, Left hip, Age-related Osteoporosis with Current Pathological Fracture, Vertebra (e), Subsequent Encounter for Fracture With Routine Healing, and Other Spondylosis with Myelopathy, Lumbar region.</p> <p>R1's Same Continuity of Care documents the following medications orders:</p> <p>Hydrocodone-Acetaminophen 5 milligrams (mg) / 325 mg tablet one tablet, oral, as needed every eight hours for pain, last administered 06/30/2024 at 12:32 PM,</p> <p>Acetaminophen 325 mg tablet , two tablets, oral, every six hours as needed for mild pain, last administered 07/05/2024 at 12:29 PM.</p> <p>R1's Minimum Data Set (MDS) dated [DATE] documents the following: Brief Interview of Mental Status (BIMS) score of 14, out of a possible 15, which indicates no cognitive impairment. The same MDS documents R1 has occasional mild pain and receives as needed pain medications as well as non-pharmacological interventions.</p> <p>R1's Medication Administration Record dated 6/1 - 6/30/24 documents the following medication administration: Hydrocodone-acetaminophen - Schedule II (controlled substance/narcotic) tablet; 5-325 mg; Amount to Administer: 1 tab; oral at 4:08 am and 12:32 pm (by electronic medical record date). The same MAR documents V10, Licensed Practical Nurse administered Acetaminophen, 325 mg, two tablets, oral route at 3:42 pm, upon finding R1 had not been administered the charted Hydrocodone as documented by V5, Registered Nurse. (See misappropriation investigation witness statement below)</p> <p>R1's Care Plan dated 5/30/24 documents to administers R1's pain medications as ordered by the physician.</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>R1's Progress Note dated 7/1/24 at 7:30 am documents: Abuse allegation received, investigation initiated, all parties notified.</p> <p>R1's Individual Resident Controlled Substance Record dated 6/8/24 - 6/30/24 documents R1's Hydrocodone-Acetaminophen 5 mg / 325 mg supply had one tablet removed for administration, on 6/30/24 at 4:09 am, and again at 12:50 pm. The hand written removal documentation showed a discrepancy compared with MAR above administration, which documents the medication administration occurred before the medication was removed from the narcotic lock box.</p> <p>The facility final facsimile report to Illinois Department of Public Health dated 7/5/24 at 10:24 am documents the following: Resident (confirmed as R1) reported that they (identified later as R1 and R2) did not receive pain pills. Upon review of the narcotic log by (V2) Director of Nursing , pain pill was (were) confirmed signed out (removed by a nurse, from resident controlled substance supply) by (Private Nurse Staffing Company) Registered Nurse (V5),</p> <p>The facility investigations alleged misappropriation of R1 and R2's narcotic medication and included a Witness Statement dated 6/30/24. The Witness Statement was signed by V10, Licensed Practical Nurse (LPN). The witness statement documents the following: (R1) - asked for Tylenol - it was charted out (Individual Resident Controlled Substance Record) that she (R1) had 2 (two) Norco (Hydrocodone combined with acetaminophen) on day shift. Resident (R1) stated she had not had any pain medicine today.</p> <p>On 7/18/24 at 8:25 am V1, Administrator/ Abuse Prevention Coordinator stated he had been in contact with the private nurse staffing agency that employs V5, Registered Nurse (RN). V5, RN had not returned facility calls. V1 notified the private nursing agency of the alleged misappropriation of residents medication by V5, RN, and that an investigation was in progress therefore, V5 Agency RN was removed from the facility nurse schedule. V1, Administrator/ Abuse Prevention Coordinator also stated during the investigation, V1 became aware that V5, RN had V5's Nurses Licensed suspended in 2015 for drug diversion, and reinstated in 2023. V1, provided V5's Licensed Verification Report that confirmed V1's findings during the investigation. V1 also stated he was in contact the local police department. V1 stated he has shared the facility misappropriation of narcotic medications investigation findings with the local police department. V1 stated he informed the local police department V1 would like V5, RN to be prosecuted to the full extent of the law, so she cannot do this again.</p> <p>On 7/18/24 at 8:30 am R1 stated she receives Tylenol (Acetaminophen) as needed for general discomfort, but when she is in severe pain, she does request Hydrocodone. R1 could not recall the last day she asked for Hydrocodone, it was sometime a month or so ago. R1 also stated There was a time a couple weeks ago (later identified as 6/30), I ask a nurse (later identified as V10, Licensed Practical Nurse) for Tylenol and she told me I had already received my Hydrocodone. That nurse said it had been written down by the previous nurse (later identified as V5, Agency Registered Nurse), and I had already taken it. That was not true. I had not asked or received Hydrocodone, and I told the second nurse (V10, LPN) so. I thought the first nurse (V5, RN) had maybe given my Hydrocodone to another resident. I am not sure what happened to it. R1 also stated her pain is usually managed well by re-positioning or Tylenol. R1 stated R1 does not like to take the Hydrocodone because it makes her feel loopy, and she only needs the Hydrocodone when she has severe pain.</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 7/18/24 at 8:50 am V2, Director of Nursing (DON) stated We continued to call, to try to get (V5, RN's) side of the story, but she never called back. Based on all the information we have, I feel she was guilty. We have a QA (Quality Assurance) meeting next week, and I am sure we will be discussing this (R1 and R2 misappropriation investigation) at length. We had an IDT (Interdisciplinary) morning meeting, after the investigation was initiated. The meeting included (V9) President of our Board, and department heads. We talked about this investigation at length.</p> <p>2. R2's Physician Order Report Sheet (POS) dated 6/01/24 - 6/30/24 documents the following and diagnoses and medications: Tramadol - Schedule IV (controlled substance, level four, narcotic) tablet; 50 mg, one tablet oral, every eight hours as needed for diagnoses of Pain, unspecified.</p> <p>The same POS, documents Acetaminophen with Codeine - Schedule III (also known as Tylenol #3, controlled substance, level three narcotic) tablet; 300 mg -30 mg, 1 or 2 tablets, oral, every four hours for pain, diagnosis: Spinal Stenosis, Lumbar Region Without Neurogenic Claudication - L2-L5.</p> <p>R2's Progress Note dated 7/1/24 at 7:50 am documents: Abuse allegation received, investigation initiated all parties notified.</p> <p>R2's MDS dated [DATE] documents R2' BIMS score of 15 out of a possible 15, which indicates no cognitive impairment. R2's MDS also documents R2 has occasional pain moderate level and receives as needed medication.</p> <p>R2's Care Plan dated 6/6/24 documents R2 is to receive pain medications as ordered by the physician.</p> <p>R2's Medication Administration Record (MAR) dated 6/01/24-6/30/24 documents the following medications were administered: Tylenol # 3 (does not document if one or two tablets were administered) on 6/30/24 at 12:37 pm, by V5, RN and Tramadol on 6/30/24 at 9:02 am -by V5, RN.</p> <p>R2's Individual Resident Controlled Substance Record dated 6/5-7/13/23 documents R2's</p> <p>Tramadol - Schedule IV (narcotic) 50 mg tablet supply, had one tablet removed by V5, RN on 6/30/24 at 8:00 am (not given according to MAR, until 9:02 am). V5 also removed two tablets of Tylenol # 3 on 6/30/24 at 8:40 am, for a total of three narcotic medication tablets removed from narcotic lock box, within an hour). There is nothing documented on R2's MAR that the two 8:40 am, Tylenol #3 tablets removed from supply were administered. The same supply of R2's Tylenol #3 document two additional tablets where removed by V5, RN at 1:20 pm. By R2's same hand written narcotic removal documentation of control substance sheet, there is a discrepancy compared with the MAR above administration which documents R2 Tylenol #3 two tablets were administered 43 minutes before the tablets had been removed from R2's double locked supply of Controlled Substances.</p> <p>The facility alleged misappropriation of R1 and R2's narcotic medication investigation, includes a Witness Statement dated 6/30/24, signed by V10, Licensed Practical Nurse (LPN). The witness statement documents the following: (R2) - asked for Tramadol- it was charted out (Individual Resident Controlled Substance Record) that he (R2) had Tramadol and Tylenol # 3, x 2 (times two) - Resident (R2) stated he did not have Tylenol #3 today and only a Tramadol this morning. R2 was not available for interview due to an unrelated hospitalization during this survey. R2's BIMS above confirms R2 had no cognitive impairment when R2 stated to V10, LPN that R2 did not receive the Tylenol #3 on 6/30/24 .</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 facility final facsimile report to Illinois Department of Public Health dated 7/5/24 at 10:24 am documents the following: Resident (confirmed as R1) reported that they (identified elsewhere as R1 and R2) did not receive pain pills. Upon review of the narcotic log by (V2)Director of Nursing, pain pill was (were) confirmed signed out (removed by a nurse, from resident controlled substance supply) by (Private Nurse Staffing Company) (V5) Registered Nurse.</p> <p>The (facility name) Home: Abuse, Neglect and Exploitation Policy dated 6/16/24 documents the following:</p> <p>The resident has the right to be free from abuse, neglect, misappropriation of resident property and exploitation. This includes, but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. It is the policy of The (facility name) Home to provide protections for the health, welfare and rights of each resident by developing and implementing written policies and procedures that prohibit and prevent abuse, neglect, exploitation and misappropriation of resident property.</p> <p>The same policy documents: Definitions: Misappropriation of Resident Property: The deliberate misplacement, exploitation, or wrongful, temporary or permanent taking or use of a resident's belongings or money without the resident's consent.</p>		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.</p> <p>31642</p> <p>Based on observation, interview and record review the facility failed to secure medications, including controlled substance medications by failing to close the medication room door, and lock the medication cart. This failure had the potential to affect three of seven residents (R4, R5 and R6) reviewed for misappropriation of medications on the sample list of seven.</p> <p>Findings include:</p> <p>On 7/18/24 at 2:30 pm, R4, R5, and R6 were independently propelling their wheelchair outside of the Lakeside unit medication room. The medication room door was wide open, and propped with an exercise barbell. R4 asked this surveyor if surveyor would give R4 pain medicine. R4 stated Honey, I need my medicine, my back is hurting so bad. Please get my medicine. I need to go to the bathroom. I need my medicine first. This surveyor explained that this surveyor is a a visitor to the facility, and can't give R4 medication, but surveyor would find R4's nurse. R4 stated, Can you rub my back it hurts so bad. R5 propelled her wheelchair over to R4 wheelchair, to rub R4's back. All three resident wheelchairs were now grouped together and parked, less than a foot from the open medication room doorway. There was no nurse in the medication room. The medication cart was in the medication room, and within a foot of the opened medication room doorway (less then two feet total from the residents). The medication cart was unlocked, as evidenced by a stainless-steel key entry post, sticking out from the front of the medication cart. There were no staff members present down any of the three halls that junction at the medication room. This surveyor keep continues observation of the medication room and R4, R5, and R6 while looking for a staff member down the halls. At 2:37 pm an unidentified Certified Nursing Assistant (CNA) heard R4 ask again to be toileted. The unidentified CNA pushed R4's wheelchair down the hall and stated she will take R4 to the bathroom. The medication room door remained open, and without staff supervision until 2:39 pm (nine minutes, total). V8, Registered Nurse (RN) came out of an unidentified resident room and came to the medication room. V8, RN stated she had just given R4 pain medication about fifteen minutes prior. V8, RN then confirmed the wide-open medication room door was propped open with a weighted exercise barbell, and the medication cart was unlocked. V8, RN confirmed the narcotic medication lock box was in the unlocked medication cart therefore narcotics were not double locked. V8 stated I know better then to leave my medication cart unlocked or the med (medication) room door open.</p> <p>(R4, R5 and R6) are all somewhat confused at times and do wander the halls. I can't say why I did that. I always lock it (medication cart) and close the door. At 2:43 pm V2, Director of Nursing (DON) entered the medication room and acknowledged the medication room was open and the medication cart was unlocked, leaving all medication accessible to R4, R5, and R6 who were in the hall outside the medication room. V2, DON also acknowledged the narcotic controlled medications on the cart were only locked in the key lock box inside the medication cart, and not two locks as required by facility medication storage policy.</p> <p>The facility policy The (facility name) Home: Controlled Substance Administration & Accountability dated 7/05/24 documents the following:</p> <p>(continued on next page)</p>		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>It is the policy of The (facility name) Home to promote safe, high quality resident care, compliant with state and federal regulations regarding monitoring the use of controlled substances. The facility will have safeguards in place in order to prevent loss, diversion or accidental exposure. The same policy documents Storage and Security: Resident-specific controlled substances are stored under double lock until administered to the resident, a paper system is utilized for 24 hour recording of controlled substance use.</p> <p>The facility policy The (facility name) Home: Medication Storage dated as revised 07/18/24 (during the survey) documents the following: It is the policy of The (facility name) Home to ensure all medications housed on our premises will be stored in the medication/treatment carts and/or medication rooms according to the manufacturer's recommendations and sufficient to ensure proper sanitation, temperature, light, ventilation, moisture control, segregation, and security. Policy Explanation and Compliance Guidelines: Schedule II, III, IV and V medications are stored under double-lock and key. Only authorized personnel have access to medication storage areas.</p>		