

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 146080	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/18/2024
NAME OF PROVIDER OR SUPPLIER Countryview Care Center-Macomb		STREET ADDRESS, CITY, STATE, ZIP CODE 400 West Grant Street Macomb, IL 61455	

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>32875</p> <p>Based on interview and record review the facility failed to prevent misappropriation of property for 1 resident (R1) of 3 residents reviewed for misappropriation of property in the sample of 4.</p> <p>The Findings include:</p> <p>Abuse Prevention Program policy 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. 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. This facility therefore prohibits mistreatment, exploitation, neglect or abuse of its residents, and has attempted to establish a resident sensitive and resident secure environment. Misappropriation of Resident Property means the deliberate misplacement, exploitation, or wrongful temporary, or permanent use of a residence belongings or money without the residence consent.</p> <p>The Final Investigation Report dated 4/8/24 at 8:34 PM, sent to the (State Agency) documents Upon investigation it was determined that there is a missing card of narcotics. Police investigation is ongoing. Staff member has been terminated. Facility will be replacing card of narcotics. Will send updates as police investigation continues.</p> <p>On 4/17/24 at 9:50 AM, V1/Administrator stated that the pharmacy had delivered medication to the facility on the night shift (4/1/24). V3/Registered Nurse/RN received the medication. V3 was the only nurse working that night. The next day (4/2/24) V1 was notified there was a card of Norco missing for R1. The police were notified, and an investigation was started. V3 was asked to come to the facility to fill out a statement and V3 refused. V1 suspended V3 and V3 never came back in the facility. V1 reviewed the video of V3 receiving the medication from the pharmacy and putting it away. V1 stated it looked like V3 put one of R1's Norco cards under the desk and put the other three cards of R1's Norco in the narcotic box. Later, V3 brought her backpack to the nurse's station.</p> <p>On 4/17/24 at 9:56 AM, V2/Director of Nursing/DON stated that V5/Licensed Practical Nurse/LPN was getting ready to pass medication to R1 and noticed that R1's cards for Norco were numbered one of four, two of four, and three of four. There was not a card four of four. V5 asked V2 about the missing card. An investigation was started, and video was watched of the medication being delivered and who had access to the medication. V3/RN had received the medication from the pharmacy. V3 was called and admitted that four cards were delivered for R1's Norco. V3 did not admit to taking one of the cards. V3 never came back to the facility after the incident.</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 4/17/24 at 12:48 PM, V4/RN stated I came to work at 6:00 AM (4/2/24). (V5/LPN) was late getting to work so I counted off both carts with (V3/RN). (V3) had the book and was checking it to what I counted. When (V5) came in (V5) checked her med cart and found that there was a medication card missing for (R1).</p> <p>On 4/17/24 at 12:47 PM, the video was observed of V3/RN checking in the medication for R1. On 4/2/24 at 3:28 AM, V3 was observed with four cards of narcotics. V3 took one card, and it looked like R1 placed it below the desk with her right hand. At 3:30 AM, V3 took the remaining three narcotic cards with her left hand and took them around the nurse's station to the medication cart. V3 filled out three Controlled Substance Proof of Use sheets for the three narcotic cards. V3 then placed the three narcotic cards in the medication narcotic box. A few minutes later V3 was seen bringing her backpack out of the medication room to the nurse's station.</p> <p>On 4/18/24 at 10:46 AM, V5/LPN stated that she was late getting to work on 4/2/24. V3 and V4 had already done the narcotic count. Before V5 started her med pass she double checked her medication cart. V5 noticed that the pink sheet from the pharmacy documented 120 tablets of Norco had been delivered for R1. V5 went to check the Pharmacy Delivery Sheet to see what quantity of Norco the pharmacy sent for R1 and what V3 had signed for. The Pharmacy Delivery Sheet for R1's Norco was gone. V5 reported her concerns to V2.</p> <p>On 4/18/24 at 6:14 PM, V10/Police Officer stated that he was called to the facility for a possible drug diversion. V10 watched the video the facility had and had a suspect. From the video V10 thought V3/RN had taken the medication. From the video V10 could not say for sure that V3 took the medication but the situation looked highly suspicious. V10 went to talk to V3 and V3 gave vague answers and did not confess. V10 also stated that he suspected V3 took the medication but did not have enough hard proof to make an arrest.</p> <p>(continued on next page)</p>		

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