

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  146106	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  10/10/2024
NAME OF PROVIDER OR SUPPLIER  Scott County Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE  Rural Route 2 Winchester, IL 62694	

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>42636</p> <p>Based on interview and record review, the facility failed to prevent misappropriation of a residents medication in 1 of 4 residents (R2), reviewed for Misappropriation in the sample of 4.</p> <p>Findings include:</p> <p>The Facility Final Report, dated 3/6/24, documents the following: On Thursday, February 29, 2024, during the evening, the administrator received notice that approximately 29.75 ml of concentrated liquid Ativan (2mg/ml) was missing from the nurse medication room properly stored in the locked refrigerator. Interviews of all staff nurses began. Management nurses reported to facility. All areas of the medication room, refrigerator, and both medication carts were searched. This same evening it was realized that pharmacy documents were missing as well (pink pharmacy sheets for usage and destruction) of missing medication. At that time large shred box was opened to find the pharmacy medication documents folded in half to be shredded. Interviews with nurses, whom all did respond by phone, were received this evening. After review of nurse schedule it was realized the time frame of the drug diversion occurred on 2/27/24. At this time, the administrator began review of surveillance for the nurse's medication room. It was found after multiple entries into the medication room by V3, LPN, and the following information to be factual and true. Camera footage shows said nurse on 2/27/24 at 2007 (8:07 PM) removing the box Ativan from the top shelf in the refrigerator door, then removes the bottle of liquid Ativan, flattens the package/box, and places the bottle in a small zipper bag and puts it in her purse. V3 then replaces the box in the trash and removes the trash. Later at approximately 2140 (9:40 PM), V3 takes her purse/bag out of the medication room/facility and to her car (just prior to 2200 (10 PM) nurse reporting to shift. V3 was spoken to multiple times and denied seeing the medication. V3 stated she was not aware of that medication and felt like she was being set up and continued to deny any involvement. On Friday 3/1/24, early morning, Pharmacy, Medical Director, Sheriff, IDPH (Illinois Department of Public Health), County Commissioners and the State's Attorney was notified. On this date the County Sheriff came to the facility to review surveillance and captured time frame when nurse is removing the missing controlled medication and takes it by putting it in her personal bag and later removes the bag from the facility to her car. Asked the surveillance company to capture time frame from incident and provide a USB drive to the facility. V3 very angry when advised she alone was being investigated for drug diversion and advised if she had anything to report or would like to speak with myself over the incident, she could and she refused. Administrator did not inform of surveillance as was instructed by law enforcement and the Department of Professional Regulations in this matter. We will continue to follow polices directly related to such event and will function to protect residents from such.</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>R2's February Physician Order Sheet, documents an order, dated 2/23/24, for Lorazepam (Ativan) oral solution 2mg (milligrams) / ml (milliliter), 0.25ml every 4 hours as needed for anxiety/agitation.</p> <p>On 10/10/24 at 8:35 AM, V1, Administrator, stated a bottle of Ativan was observed to be missing. The facility notified local law enforcement, IDPH and the Physician. V1 stated after a review of the facility cameras, it was determined that V3, Former LPN (Licensed Practical Nurse), had taken the medication, disposed of the box and pharmacy delivery sheet and left the facility with the medication in her purse. V1 stated in working with law enforcement, the video footage was given to them. V1 stated V3 was immediately suspended and then terminated. V1 stated IDFP (Illinois Department of Financial and Professional Regulation) was also notified. V1 stated the medication belonged to R2. V1 stated R2 had passed away and the medication was in the refrigerator in a locked box in the locked medication room, waiting to be disposed of due to having to have 2 nurses witness the destruction. V1 stated they have not had any other drug diversions, theft or misappropriation since this incident. V1 stated prior to V3 being hired a background check was completed with no findings, her license was reviewed on the IDFP website with no disciplinary actions and her reference checks didn't reveal any concerns with prior employers.</p> <p>The Abuse, Neglect and Mistreatment Prevention Program Facility Procedures Policy, dated 1/26/24, documents the following: This facility advocates for the prevention of, reporting of, and immediate investigation of allegations of abuse, neglect, mistreatment of residents and misappropriation of resident funds or property.</p>		