Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6012322	A. BUILDING: ________ B. WING ________	C 02/10/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOWEAQUA NRSG & RETIREMENT CTR	525 SOUTH MACON STREET MOWEAQUA, IL 62550

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S9999	Final Observations	S9999		

STATEMENT OF LICENSURE VIOLATIONS:

300.610a)
300.1210b)
300.1610a)1)
300.1830b)
300.3210g)
300.3240a)
300.3240b)

Section 300.610 Resident Care Policies
a) The facility shall have written policies and procedures governing all services provided by the facility. The written policies and procedures shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee, and representatives of nursing and other services in the facility. The policies shall comply with the Act and this Part. The written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, documented by written, signed and dated minutes of the meeting.

Section 300.1210 General Requirements for Nursing and Personal Care
b) The facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive resident care plan. Adequate and properly supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident.

Attachment A
Statement of Licensure Violations

Illinois Department of Public Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE 02/27/15

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Section 300.1610 Medication Policies and Procedures
a) Development of Medication Policies
1) Every facility shall adopt written policies and procedures for properly and promptly obtaining, dispensing, administering, returning, and disposing of drugs and medications. These policies and procedures shall be consistent with the Act and this Part and shall be followed by the facility. These policies and procedures shall be in compliance with all applicable federal, State and local laws.

Section 300.1830 Records Pertaining to Residents' Property
b) When purchases are made for a resident from the resident's personal monies, receipts shall be obtained and retained that verify the date, amount, and items purchased.

Section 300.3210 General
g) The facility shall develop procedures for investigating complaints concerning theft of residents' property and shall promptly investigate all such complaints.

Section 300.3240 Abuse and Neglect
a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident.
b) A facility employee or agent who becomes aware of abuse or neglect of a resident shall immediately report the matter to the facility administrator.

These requirements are not met as evidenced by:

Based on interview and record review the facility

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failed to ensure residents are free of misappropriation of resident property for seven of seven residents (R2,R4,R5,R6,R7,R8,R3) reviewed for theft, on the sample of 25. A facility staff member failed to immediately notify the Administrator of being asked by another staff member to assist with cashing a resident's check as potential theft (misappropriation of property). This staff member failed to recognize this action as misappropriation of resident's property as defined in facility policy. These failures resulted in the deliberate forgery and cashing of R2's personal check without her consent. R2 experienced anxiety and financial harm by the forgery and cashing of her personal check by staff. The facility also failed to have a policy-driven operating system in place to prevent the diversion of narcotics, resulting in the theft by staff of narcotic medications belonging to residents (R4,R5,R6,R7,R8). In addition facility staff failed to recognize and identify misappropriation of resident property by failing to immediately report the theft of a lottery ticket belonging to R3, as directed by facility policy.

Findings include:

1. The Physician Progress Note dated 12/13/14 states R2 has diagnoses of Chronic Obstructive Lung Disease, Congestive Heart Failure, Atrial Fibrillation and a history of Bipolar Disorder and Anxiety. The Minimum Data Set (MDS) dated 12/5/14 states R2 has no cognitive impairment or behaviors. The Admission Face Sheet dated 11/28/14 documents that R2 was admitted to the skilled unit from the attached independent living apartments on 11/28/14. The Physician's Order dated 1/14/15 states its okay to discharge R2 back to the Independent Living Unit.

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On 2/4/15 at 1:15pm R2 stated she received her bank statement on Saturday [1/24/15] and was going over the statement on Saturday night. R2 stated there were five checks listed on the statement and "when I got to the last one [check]-I thought it wasn't mine-it was made out to [E3, (CNA) Certified Nurse Aide]. I immediately told [E12, Independent Living Supervisor] on Sunday [1/25/15] morning. [E12] made a couple of phone calls and she and [E4, Social Service Director] came and talked to me.

The written statement by E12, Independent Living Supervisor states, "On January 23, 2015, [R2] asked me to look at her bank statement....showed me the part of the statement that was a photocopy of the check that had gone through the account. As I looked at the copies, it was very clear that one of the checks had not been signed by [R2], as the signature was completely different. After asking [R2] if she knew the person the check was made out to, [R2] said she wasn't sure, but thought ...this happened because she had left her checkbook on the cabinet in her room on the nursing [skilled] side, when she was staying over there......." The statement documents that E12 immediately reported the issue to E5, Independent Living Director.

On 2/4/15 at 1:55pm E5, Independent Living Supervisor stated that E12 reported the problem with R2's check to her on 1/25/15. E5 stated after looking at the bank statement "I knew there was a problem." E5 stated she immediately reported the issue to E1, Administrator and was told to call the police. E5 stated she talked to Z2 (Police Chief) and also called E4, Social Service Director.

On 2/4/15 at 2:10pm E4 stated she went in on

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Sunday (1/25/15) and interviewed R2. E4 stated she interviewed E3 and E6, CNA's (alleged perpetrators) about R2's check and immediately suspended both of them.

The Police Department Case Report dated 1/28/15 states, "On 1/25/15....contacted...in regards to a possible theft from a resident [R2]..... [R2] ...not aware she had written a check for the amount of $375.00 dollars on 12/14/14....had never written a check out to the name posted on the check [E3, CNA] and never ordered [cosmetic] products which was listed in the Memo area of the check.....[E3]stated she was contacted by [E6, CNA] who asked [E3] if she would cash a check for her [E6] for [cosmetic] products.....on arrival at...bank...[E6] handed [E3] a check made out for $375.00 dollars, however did not have a name on the check....[E6] told [E3] to write her own name on the check so it would be easier to cash..[E3] complied and then wrote [cosmetic company name] in the memo area so [R2] would remember what the check was for.... [E3] then cashed the check and had the teller hand the cash over to [E6]....[E3] was asked if she knew the check to be stolen to which she stated no....[E6] admitted she observed the check laying on the counter top of the nurses station and took it. [E6] admitted to signing [R2's] name on the check and using the money to repair her vehicle....." The report states that E6 was arrested for "Fraud" and "Aggravated Identity Theft....."

On 2/4/15 Z2, Police Chief stated he arrested E6, CNA after she fully confessed during the investigation. Z2 stated E3, CNA "truly believed that it was for [cosmetic] product."

On 2/5/14 at 12:05pm E3, CNA stated, "[E6]

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asked for a favor- she got a check from [R2] to purchase [cosmetics]-it was around Christmas-so it made sense to me...asked if I would cash it for her.....Went to bank and [E6] handed the check to me--didn't really look at the amount-saw [R2's] signature...[E6] didn't want to put her name on the check--[E6] said [R2] left the payee part of the check blank so whoever was cashing it could put their name on it-easier. First I told her [E6] to put her name on it and she could endorse it to me...She [E6] said it would be easier for me [E3] to put my name, so I wrote my name in the payee spot of the check and wrote [cosmetic name] in the memo section......I [E3] signed my name on the back of the check..I cashed it and [E6] told the teller how she wanted it[money]..." When asked if she had any suspicions, E3 stated, "[R2] was on our side[skilled unit] from retirement [unit]..didn't think anything of it....I knew we weren't supposed to get money from residents--from abuse training...I asked [E6] if she had permission to do it, she [E6] assured me she had permission to do it [cash R2's check]. I did not report it to anyone because I assumed she [E6] had permission. I was not aware it was a problem until I got suspended [1/25/15]."

On 2/4/15 at 1:15pm R2 stated that she "made the check out [E3] did it for somebody else [E6, CNA]...she was dismissed. My checkbook was over there on the skilled side-unit the whole time-checkbook was in the drawer with some bills....." R2 stated she called her bank on Monday (1/26/15) and talked to them about the forged check ($375.00). R2 stated she is missing another check besides the one which was "forged." R2 stated she was told by the bank that they "will not reimburse" her for the amount of money the check was forged for, which is three hundred and seventy five dollars. On 2/5/15 at

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1:00pm R2 stated that "I have never bought ....cosmetics, did not ask for a book or anything." R2 confirmed that she did not order any cosmetics from E6, CNA. R2 stated she "felt terrible about the loss of the three hundred and seventy five dollars-gone-bank will not reimburse me for this-I have not been reimbursed by anybody at this point. I was saving to get a different car. I never thought I would have to mistrust someone-people are nice here-never dreamed one of the workers would take advantage of anyone-Unbelievable-never had second thoughts-it happened- really bad...Oh my gosh is this going to result in stolen identity-very worried.."

2. The statement dated 10/28/14 signed by E14, CNA stated, "I came into work at 9:30pm on 10/27/14.....About 10:00pm....I went to get [E13, Licensed Practical Nurse, LPN] to tell her she had a phone call..she looked at me like she was lost and didn't understand. so I repeated myself..she put her hands on her head...said she had a bad headache...she went to phone, sat down and wasn't making any sense.....I said [E13] the phone isn't even to your ear...her speech was slurred......[E16, CNA] took [E13's] [blood pressure] at 11:30pm it was 78/54..I called [E15, (Former) Director of Nursing, DON] told her what was going on [E15] said she would be right there....[E16] and I walked [E13] to the couch together and layed her down.....About 12:30pm [E16, CNA, E15, DON] and I done med[medication] count. there was 2 oxycodone (narcotic medication) missing, 4 vials of Ativan (anxiolytic medication) and 1 pill of Ativan...The ambulance came and got [E13]..."

On 2/9/15 at 1:40pm E14, CNA confirmed the statement she wrote was accurate to the events

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which occurred with E13, LPN on 10/27/14. E14 stated E13 "could barely talk on phone...we [E16,E14] told her we were going to call an ambulance-walked her to the couch-[E13] could barely walk-within minutes she was out--called [E15] and she came in...Did a pill count with [E15]-short Norco (oxycodone) and vials of Ativan..." E14 stated she thought E13 was the only nurse on that night.

The statement dated 10/28/14 signed by E16, CNA states, "I arrived at work at 9:20pm...noticed around 10:00pm [E13] was having slow reaction times...trouble understanding what people were telling her...[E13] was walking slow and half stumbling...sitting at nurse's desk with hands in her face and looked....as though she was falling asleep...[E14]... had to direct [E13] to sit down and talk to person on the phone...left to do some work......returned [E13] was holding the phone to her chest and fell asleep...started drooling...laid her on couch...[E14] called [E15]...came in and called ambulance...we[E14,E16,E15] did med [medication] count.....and noticed error in count..2 pills of oxycodone missing, 4 vials of ativan and 1 pill of ativan missing."

The statement dated 10/28/14 and signed by E15, (Former) DON states, "...received call at 11:47pm [10/27/14] from [E14,CNA] that nurse [E13] was 'slurring her words, b/p[blood pressure] was 78/54.....head hurt'....said I would be right in.....arrived at ....[E13] was sleeping on the couch....did not respond to me calling her name...I called 911....asked ambulance driver for the keys to the med carts....had both [E14, E16] present when I counted narcotics[10/28/14]...I found the following items (individually packaged medications) missing and not signed out: Oxycodone/Apap 10/325mg[milligrams]-2 pills

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missing, count said 102 and only 100 were there[R4]; Lorazepan [Ativan] 0.5mg-1 pill missing, count said 26 and only 25 were there [R5]; Lorazepam 2mg/ml[milliliter] vials, count said 5 vials, only 3 vials were there [R6]; Lorazepan 2mg/ml vials, count said 2.0 vials , [no] vials were there [R7]; the refrigerator in the med room did not have the padlock on it when we entered the room to count. I called ....evening nurse[E17,RN] asked if they had done count, he informed me yes they had and it was correct when he left. I asked him who had counted the new bottles, he informed me [E13, LPN] had told him she and [E16,CNA] had counted them. [E17] stated the oxycodone had 23 [R8], the paper written by [E13] says 21.....I called 911 [and] reported the situation to the dispatcher....I received a call from [Z2, Police Chief]..said he would be by in the morning for statements..."

R4's Controlled Substance Proof of Use record dated 10/14/14 for Oxycodone with APAP (Percocet) 10mg/325mg take one every 4 hours documents by E17, RN on 10/27/14 at 8:00pm there were 102 tablets left. The entry dated 10/28/14, no time, by E15, DON documents there were 100 tablets present. The Medication Record dated 10/1-10/31/14 documents the Oxycodone with APAP was not given at 12:00am because R4 was sleeping. The medication was scheduled to be given at 4:00am, 8:00am, 12:00pm, 4:00pm, 8:00pm and 12:00am. On 2/9/15 at 9:15am E15 confirmed she counted on 10/28/14 with E14 and E16, CNA's and there were medications missing. E15 stated R4 was to get the Oxycodone/Apap 10/32mg every 4 hours. E15 stated she spoke with R4 after E13, LPN was gone and R4 said "he never took it at 4:00am." On 2/10/15 at 1:55pm R4 stated there was a time, when depending on what nurse was working, that he

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was not awakened in the middle of the night for his dose of Oxycodone. R4 was unable to identify the name of the nurse, but stated "It's better now."

R5's Controlled Substance Proof of Use record dated 9/18/14 for Lorazepan 0.5mg one tablet every 8 hours prn (as needed) documents 26 tablets of Lorazepam on 10/25/14. The next entry is dated 10/28/14 by E15, DON and documents only 25 tablets left. The PRN Medication Information documents R5 receiving Lorazepam 0.5mg being given last on 10/25/14 at 10:00pm. On 2/9/15 at 9:15am E15, DON confirmed R5 was missing one tablet of Lorazepam.

R6's Controlled Substances Proof of Use dated 11/5/13 for Lorazepam 2mg/ml vial documents 5-5ml vials of Lorazepam were sent from the pharmacy on 11/5/13. The record does not document Lorazepam being given to R6. The only entry on the record is dated 10/28/14 by E15, DON with there being 3 vials of Lorazepam present in the medication refrigerator. On 2/9/15 at 9:15am E15, (Former) DON confirmed R6 was short 2 vials of Lorazepam when she counted on 10/28/14 after sending E13, LPN by ambulance to the hospital. E15 confirmed R6's Lorazepam was originally sent from the pharmacy on 11/5/13.

R7's Controlled Substances Proof of Use dated 10/28/13 for Lorazepam 2mg/ml vials documents 6-5ml vials were sent from the pharmacy. The entry on the record dated 4/8/14 documents R7 received Lorazepam with 2 vials remaining. The last entry on the record by E15, (Former) DON documents no vials of Lorazepam remaining. On 2/9/15 at 9:15am E15, DON confirmed R7 was missing two vials of Lorazepam. E15 stated the package with the label was also missing, only the

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Controlled Substances Proof of Use record was found in the back of the narcotics book.

On 2/9/15 at 9:15am E15 stated R8 was admitted with Oxycodone XR[extended release] 20mg and E17, RN told her there were 23 pills in the container, when they were counted by E18, LPN. E15 stated that E18 wrote 23 on the label of the bottle of Oxycodone XR. E15 stated E13, LPN counted the Oxycodone as 21 and made out a "new sheet[controlled substance record]" and placed it in the narcotic book. E15 stated when counted there were only 21 Oxycodone XR 20mg.

The undated Individual Residents Controlled Substance Record for R8 states Oxycodone 20mg po (by mouth) every 12 hours, with amount received documented as 21. There is no Oxycodone 20 mg signed out on the record. The Admission Face Sheet dated 10/27/14 documents R8 was admitted to the facility on 10/27/14. The label on the bottle documents Oxycodone Er 20mg belonging to R8, with 23 written in on the label.

On 2/9/15 at 1:55pm E18, LPN stated she counted a new resident's (R8) medication (Oxycodone XR) and wrote the amount on the label of the bottle of medication. E18 stated she was standing next to E17, RN when she counted the medication. E18 stated the statement she documented on 10/28/14 is accurate.

The statement dated 10/28/14 signed by E18, LPN states, ".....The narcotic count at the end of my shift on 10/27/14 was correct for [Medication] Cart 2. I completed the count with LPN [E13]."

The statement dated 10/28/14 signed by E17, RN states, ".....On....10/27/14 I counted narcotics at

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S9999	Continued From page 11	S9999		

the end of my shift with LPN [E13]. Following the count, keys to the med card were turned over to [E13] as we both agreed the count was correct. On 2/9/15 at 1:45pm E17 confirmed the statement was accurate to what occurred on 10/27/14.

On 2/10/15 at 10:45am E1, Administrator stated that staff were not counting the vials of Lorazepam kept in the medication refrigerator when they counted narcotics. E1 confirmed since staff were not counting the vials of Lorazepam, they don't know for sure when they disappeared.

The Police Report dated 10/28/14 states, "[E13, LPN] was asked about the incident of her being unresponsive and unable to function the night (10/27/14) that the prescription medications was missing. [E13] stated she knew nothing about the missing prescriptions and stated her pill count should be correct.....[E13] stated she currently has a prescription for Alprazolam and Tramadol....and ...for Hydrocodone for 7 days due to a dental issue.....asked when she had ingested the last Hydrocodone pill to which she stated on 10/27/14 at about 11:00am.....[E13] was then handed over to......Jail for booking on for 2 outstanding in-state warrants for Possession of a controlled substance.."

On 2/5/15 at 11:15am Z2, Police Chief stated [E13] is due in court on 3/6/15 and he will be arresting her after he is in possession of all the facts involving the incident with missing prescription drugs which occurred on 10/27/14.

3. The Physician Order Sheet dated 2/1-2/28/15 states that R3 has a diagnosis of Dementia. The MDS dated 12/15/14 states that R3 has severe cognitive impairment.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6012322	A. BUILDING: ___ B. WING ___	C 02/10/2015

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S9999	Continued From page 12	S9999		

Continued From page 12

The untitled and unsigned facility form states, "On 1/17/15 at 10:00am, Report made that housekeeper [E8] was cleaning [R3's] resident room when she found a lottery ticket and placed the ticket in her wallet. [E8] was suspended immediately. Abuse investigation initiated."

The statement dated 1/19/15 by E11, Housekeeper states, "On Friday the 16th of January, 2015, I observed [E8] putting a [state lottery] ticket in her wallet. [E8] said she found it under [R3's] bed. I did notify my supervisor on Saturday January 17, 2015."

On 2/9/15 at 12:50pm E11, Housekeeper stated he went to the custodian' room on 1/16/15 around 12:40pm, and overheard E9, Housekeeper telling E8 to put the lottery ticket back on the counter in R3's room. E11 stated he saw E8 put the lottery ticket in her wallet instead. E11 confirmed that E8 worked the rest of her shift on 1/16/15. E11 stated he reported the incident to E10, Housekeeping Supervisor the next day (1/17/15).

The statement dated 1/19/15 by E9, Housekeeper states, "On Friday 1/16/15, I was approached by [E8, Housekeeper] asking how long a [lottery] ticket was still valid. When I asked her why, [E8] said she had found a ticket under [R3's] bed. It was not valid but she folded it up and put it in her wallet.....I did notify my supervisor on Saturday the 17th of January 2015."

On 2/9/15 at 1:10pm E9, Housekeeper stated she was told by E8 that she found a lottery ticket under R3's bed. E9 stated she told E8 to put the lottery ticket back (in R3's room), but E8 folded the ticket and put it in her wallet. E9 stated her

Illinois Department of Public Health

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	IL6012322	A. BUILDING: ______ B. WING ______	C 02/10/2015

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S9999	Continued From page 13	S9999		

supervisor (E10) was off that day, so she reported the incident the next day (1/17/15) to E10, Housekeeping Supervisor.

The undated and unsigned Final Report states...."[E8] picked up an old lottery ticket when she was cleaning a resident's [R3] room...[E8] stated she put it in her pocket to see if it was good...stated she took the ticket back to the [R3's] room after lunch that day....stated she put it back because she knew that if she left the building with the ticket, it would be theft....the final reporting of this incident resulted in an unfounded accusation of abuse..."

On 2/5/15 at 12:30pm E1, Administrator stated that two housekeepers, E9 and E11 saw E8 put the lottery ticket belonging to R3, in her wallet. E1 stated there was a delay in reporting of one day. E1 stated her expectation is for staff to report allegations immediately to the Administrator.

The Abuse Prevention Policy dated 11/21/14 states, "Misappropriation of resident property is defined as the deliberate misplacement, exploitation, or wrongful, temporary or permanent use of a resident's belongings or money without the resident's consent."

(B)