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
	IL6000392	A. BUILDING: ______ B. WING ______	C 08/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HIGHLAND OAKS	2750 WEST HIGHLAND AVENUE ELGIN, IL 60123

(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	Final Observations	S9999		

Statement of Licensure Violation
300.3210t)

Section 300.3210 General
t) The facility shall ensure that residents are not subjected to physical, verbal, sexual or psychological abuse, neglect, exploitation, or misappropriation of property.

This REQUIREMENT was not met as evidenced by:

Based on interview and record review the facility failed to prevent the diversion of residents' controlled substances. this applies to 4 of 4 residents (R1, R100, R101, R102) reviewed for controlled substances in the sample of 6.

1. On 8/14/24 at 9:52 AM, V1 (Administrator) stated the first missing controlled substance was identified with R100's Norco (A combination narcotic and over the counter pain medication) on or about 7/17/24. V1 stated the missing Norco punch card was identified when R100's Daughter notified the facility she did not want R100 taking Norco. V1 stated nursing staff went to the medication cart containing R100's Norco and only 3 of the 4 medication punch cards were present. V1 stated, following an extensive search of the facility, the missing card of Norco was not found. V1 stated during the investigation of the missing Norco card, 4 other missing controlled substances were found for four different residents. V1 stated the only explanation for R1, R100, R101, R102, and R103's missing controlled substances is diversion.

R100's Controlled Drug Receipt / Record / Disposition (commonly referred to as a count

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S9999	Continued From page 1	S9999		

sheet or controlled substance count sheet) showed 100 tablets of Norco were delivered to the facility on 6/28/24. R100's count sheets showed 4 punch cards, each containing 25 tablets, were delivered. The count sheets showed each individual punch card had its own corresponding count sheet. The count sheets showed the available Norco cards were destroyed/wasted on 7/23/24 with two nurses witnessing the waste. The faciltiy was only able to provide 3 of the 4 count sheets. The facility was not able to locate the missing count sheet or missing Norco punch card (25 tablets of 5 milligram/325 milligram hydrocodone/acetaminophen tablets were diverted).

R100's Medication Administration History (MAR, medication administration record) showed for the months of June 2024 and July 2024 there were no documented doses of Norco dispensed to R100.

On 8/14/24 at 12:30 PM, V2 (Director of Nursing/DON) stated the medications for each resident belongs to that resident. V2 stated the residents, and their families pay for the medications. V2 stated R100 is missing a card of Norco (25 tablets) and there is no explanation, other than diversion.

The facility's Abuse and Neglect Prevention Protocol Policy showed, "Misappropriation of resident property means using a resident's cash, clothing, or personal possessions without authorization by the resident or the resident's authorized representative..."

2. On 8/14/24 at 12:30 PM, V2 (DON) stated R101 had three cards of Norco, each containing

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S9999	Continued From page 2	S9999		

30 tablets, delivered on 5/8/24. V2 said the first card would have been started the evening of 5/8/24 and completed 10 days later. V2 said R101's Norco order was for one tablet to be given three times a day (6:00 AM, 1:00 PM, and 7:00 PM). V2 said R101's Norco should last approximately 10 days. V2 said the time span for the first missing card of Norco from 5/8/24 to 5/18/24 is most likely due to a lost count sheet and not theft; however, V2 said the second punch card was completed on 5/28/24 and the new delivery of Norco (delivered on 5/27/24) was started on 5/28/24. V2 stated she was not able to account for the third card (30 tablets) of R101's Norco and the only explanation is diversion.

R101's Norco count sheets showed the pharmacy delivered on 4/5/24, three punch cards of Norco with each card containing 30 tablets (90 in total). The three count sheets showed this delivery was started on 4/7/24 and the third Norco punch card was completed on 5/8/24 at 5:30 PM.

R101's Norco count sheets showed the pharmacy delivered on 5/8/24, three punch cards of Norco with each card containing 30 tablets. The count sheet, which would have started on or about 5/8/24 and completed on or about 5/18/24, was not provided. The second count sheet showed the second card was completed on 5/28/24 at 5:55 AM.

R101's Norco count sheets showed the pharmacy delivered on 5/27/24, two punch cards of Norco with each card containing 30 tablets (60 tablets in total). The first count sheet showed the first dose from this delivery was started on 5/28/24 at 1:00 PM. (The third card of Norco, delivered on 5/8/24, was not used and is not accounted for.)

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S9999	Continued From page 3	S9999		

Continued From page 3

3. On 8/14/24 at 12:30 PM, V2 (DON) stated R102 is missing a card of tramadol (narcotic controlled substance). V2 said the pharmacy delivered on 5/1/24, 3 cards containing 30 tablets and only two of the cards can be accounted for. V2 said the only explanation for the missing card is diversion.

R102's count sheets showed the pharmacy delivered three cards of tramadol, each card containing 30 tablets. The count sheets showed the tramadol order was for one tablet of tramadol to be given every 8 hours as needed for pain. The count sheets showed they were delivered on 5/1/24, the first dose was given on 5/4/24 at 5:30 AM, and the final dose for the first card was given on 5/13/24 at 9:22 PM. The second count sheet of tramadol was started on 5/14/24 at 5:00 AM and completed on 5/23/24 at 12:25 PM.

R102's count sheets showed the pharmacy delivered four cards of tramadol, each card containing 30 tablets. The count sheets showed they were delivered on 5/24/24 and the first dose from this delivery was given on 5/24/24 at 8:46 PM. (The third and final card from the 5/23/24 delivery was not accounted for.)

4. R1's count sheet showed the facility received, on R1's behalf, 120 tablets of 50 milligram (mg) tramadol, a schedule IV narcotic pain medication. The count sheets showed the tablets were delivered on 5/13/24 and were dispensed in four separate punch cards, each card containing 30 tablets of tramadol. R1's count sheet showed each individual punch card was delivered with its own accompanying count sheet (4 punch cards, 4 count sheets). The first dose of the first punch card of tramadol, from the delivery on 5/13/24, was dispensed on 5/16/24 at 11:59 AM. The final

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S9999	Continued From page 4	S9999		

dose of the first card was given on 5/26/24 at 12:25 PM. The second punch card was started on 5/26/24 at 9:00 PM and the final dose of this card was given 6/5/24 at 11:40 AM. The third punch card was started 6/5/24 at 9:00 PM and completed on 6/15/24 at 5:01AM (this completes 90 tablets of 120 tablets delivered on 5/13/24). Following the completion of R1's third card of tramadol, the next dose given was on 6/15/24 at 11:50 AM. The dose given on 6/15/24 at 11:50 AM was from a new delivery of 120 tablets of tramadol, which was delivered to the facility on 6/12/24. (The fourth card of tramadol delivered on 5/13/24 was not accounted for.)

On 8/14/24 at 12:30 PM, V2 (Director of Nursing) stated the facility was not able to account for R1's missing card of tramadol delivered on 5/13/24. V2 stated the only explanation for this missing tramadol punch card is theft. V2 stated tramadol is double locked and only the nurses on duty have access to the controlled substances. V2 stated the medications maintained by the facility are the resident's property. V2 said controlled substances are the most likely medications to be diverted for either financial gain or personal use.

On 8/14/24 at 9:52 AM, V1 (Administrator) stated the facility was not able to locate R1's missing card of tramadol. V1 stated it appears a nurse took R1's count sheet and his punch card of tramadol. V1 stated the medications are the resident's property.

(B)