| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 145722 | A. BUILDING _____ B. WING _____ | 03/16/2020 |

| NAME OF PROVIDER OF SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP |
|---|---|
| UNITED METHODIST VILLAGE, NORTH CAMPUS | 2101 JAMES STREET LAWRENCEVILLE, IL 62439 |

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

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| F 0600<br><br>**Level of harm** - Minimal harm or potential for actual harm<br><br>**Residents Affected** - Few | **Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.**<br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**<br>Based on record review and interview the facility failed to keep residents free from verbal abuse for 1 of 3 residents (R3) reviewed for verbal abuse in the sample of 11. The Findings Include: The March, 2020 physician's orders [REDACTED]. The 01/15/20 Minimum Data Set (MDS) documents R3 has a Brief Interview for Mental Status (BIMS) of a 1 which indicates R3 is severely cognitively impaired. On 03/16/20 at 3:33pm,V9 (Certified Nurse Aide/CNA) stated she was working the night shift on 02/20/20 with V19 (CNA). She was caring for R3 who has dementia and often yells out. That night, R3 was yelling out and she had gone to her room a couple of times to turn and reposition her but she continued to yell out and was trying to self transfer. Around 2:00am, she had V19 help her get R3 up. They placed R3 in a recliner near the nurse's station but she continued yelling. R3 was saying she wanted to go home, she wanted her mom and was wanting to take care of her mom. R3 does this and it was not unusual and she kept yelling with her normal confusion. She and V19 sat beside R3 trying to calm her. V8 (CNA) came over to try and calm R3 to. V9 stated that V8 began yelling at R3 in a hateful manner. V9 stated she had her cellular phone and she was videoing. When V8 began speaking to R3 she kept the audio on because of V8's demeanor. V8 told R3 it was two in the morning and she needed to stop yelling, telling her what town she was in and how old she was. V8 continued and told R3 that her Mom and Dad were dead. V10 (Licensed Practical Nurse/LPN) was working the hall and as V8 was speaking to R3, V10 yelled out V8's name. She did not say anything else to V8, but it was in a tone one would take as you need to stop. V9 stated she has heard V8 be verbally aggressive, but this was more than normal and this time she considered it verbally abusive. V8 does wear hearing aides and has a different tone, but this was not the same. V9 stated that R3 did not respond differently when V8 was speaking to her this way. V9 stated due to the relationship between V8 and V10 she did not report this to V10 and decided not to tell V17 (LPN) who was working the other side of the building. Instead, she decided to tell V4 (CNA Supervisor) when she came to work at 6:00am. V9 stated when she told V4, V4 told her to come back to the facility that day a little earlier than her 2:00pm shift and they would go to V1 (Administrator). V4 said she would tell V1 when she got to the facility. V9 stated she and V4 went to V1's office around 1:20pm on 02/20/20 and V2 (Director of Nurses) was also in the room. V9 stated she had written a statement of the event and gave it to V1. She played the recording of V8 speaking to R3 for them all to hear. V1 looked shocked when she heard the audio recording and her mouth dropped open when she heard V8 tell R3 that her mom was dead. V1 told V9 and V4 they could leave and she would speak with V8. V9 stated she is not sure what happened, but she does know that V8 continued to work. On 03/16/20 at 4:02pm, the surveyor listened to the audio recording that V9 played on her cellular phone. V9 stated the voice on the recording is V8. The voice that could be heard stated, Tell you what. Look at these eyes. I'm not kidding either. So, you want to keep this up? We can go all night. You are not going anywhere. You live here. This is your home. You are at (stated the name of the town) at the (stated the name of the facility). It is two o'clock in the dang morning and you are yelling. Your momma is dead. Your daddy is dead. You are 80 something years old. So, truth up. Suck it up. How old are you? The recording continued for a few more seconds asking R3 how old she was. When the voice on the recording said, Your daddy is dead, another voice could be heard in the background yelling out V8's name in a tone that one would take to mean stop. V9 stated the voice is V10. The manner in which the voice on the recording was speaking was in a demeaning harsh sharp tone. A hand written document dated 02/20/20 and signed by V9 details that V8 was yelling at R3. The document states, in part; V8 said very hurtful things that even hurt my feelings. Its two in the morning and your screaming for no reason. Your moms dead, your dads dead. This is the only documentation of the incident provided by V1. On 03/12/20 at 12:15am, V19 stated she was working when V8 was yelling at R3. V19 stated she felt this was verbal abuse and she did not report it because V9 stated she was going to tell V4 when she came to work that morning. V19 stated she is aware that V8 has a hearing problem, but this was different. V19 stated she was not interviewed regarding this incident. On 03/12/20 at 11:20am, V10 stated she recalls the night that V8 was trying to get R3 to calm down. She has cared for R3 for years and she is confused and does yell out. She did not feel that V8 was being verbally abusive. She was not interviewed regarding this incident. On 03/12/20 at 11:30am, V8 stated she recalls the night that she was trying to calm R3. She was not verbally abusive. She has cared for R3 for years and knows how to talk with her. She must be reoriented. V8 stated she was telling her where she was and that her mom and dad are not here anymore. V8 stated she did not tell R3 that her mom and dad were dead. V8 stated she is deaf and wears hearing aids and doesn't always know when she is talking loud. She was not questioned about this incident. V8's voice does have a different tone, but the voice heard on the recording was harsh and demeaning. On 03/11/20 at 7:00am, V1 stated V9 and V4 did come to her office on 02/20/20 and she and V2 listened to the audio recording of V8 speaking to R3. She did not feel it was abuse. V8 is hard of hearing and wears hearing aids. Her voice is gruff and she speaks loud due to her hearing problem. People interpret her differently even though she does not mean it. All the staff know they are to notify me immediately if they feel something is abuse. V9 did give her a written statement of the event. V1 stated she does not have an investigative file on this incident. V1 stated she did not investigate this as abuse and no one told her they were alleging abuse. She did not suspend V8 or interview other staff. The Facility's Freedom from Abuse, Neglect, and Exploitation Policy (Revised 9/25/18) states, in part: It is the policy of the Facility that each resident will be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this policy. Abuse is defined as the willful infliction of injury, unreasonable confinement intimidation, or punishment with resulting physical harm, pain or mental anguish. Abuse also includes the deprivation by an individual, including a caretaker, of goods or services that are necessary to attain or maintain physical, mental, and psychosocial well - being. Instances of abuse of all residents, irrespective of any mental or physical condition, cause physical harm, pain or mental anguish. It includes verbal abuse, sexual abuse, physical abuse, and mental abuse including abuse facilitated or enabled through the use of technology. Verbal abuse may be considered to be a type of mental abuse. Verbal abuse includes the use of oral, written, or gestured communication, or sounds, to residents within hearing distance, regardless of age, ability to comprehend, or disability. Examples of mental and verbal abuse include, but are not limited to: Harassing a resident. Mocking, insulting, ridiculing. Yelling or hovering over a resident, with the intent to intimidate. Threatening residents, including but limited to, depriving a resident of care or withholding a resident from contact with family and friends; and Isolating a resident from social interaction or activities. |
| F 0607<br><br>**Level of harm** - Minimal harm or potential for actual harm<br><br>**Residents Affected** - Few | **Develop and implement policies and procedures to prevent abuse, neglect, and theft.**<br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**<br>Based on record review and interview the facility failed to implement their Abuse Prevention Policy on timely reporting and thoroughly investigating an allegation of abuse for 2 of 3 residents (R3, R7) reviewed for abuse in the sample of 11. The Findings Include: 1. The March, 2020 physician's orders [REDACTED]. The 01/15/20 Minimum Data Set (MDS) documents R3 has |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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| F 0607<br><br>**Level of harm** - Minimal harm or potential for actual harm<br><br>**Residents Affected** - Few | (continued... from page 1)<br>a Brief Interview for Mental Status (BIMS) of a 1 which indicates R3 is severely cognitively impaired. On 03/16/20 at 3:33pm,V9 (Certified Nurse Aide/CNA) stated she was working the night shift on 02/20/20 and witnessed V8 (CNA) yelling at R3 and speaking in a hateful manner. V9 stated she did not report this to V1 (Administrator) at that time. Instead, she decided to tell V4 (CNA Supervisor) when she came to work at 6:00am that day. On 02/20/20 around 1:20pm, she and V4 went to V1's office to play an audio recording of the incident. V9 stated she also gave V1 a written statement of the event. On 03/11/20 at 7:00am, V1 stated V9 and V4 did come to her office on 02/20/20 and she and V2 (Director of Nurses) listened to the audio recording of V8 speaking to R3. She did not feel it was abuse. V8 is hard of hearing and wears hearing aids. Her voice is gruff and she speaks loud due to her hearing problem. People interpret her differently even though she does not mean it. All the staff know they are to notify me immediately if they feel something is abuse. V9 did give her a written statement of the event. V1 stated she did not investigate this as abuse and no one told her they were alleging abuse. V1 stated she does not have an investigative file on this incident nor did she report it to IDPH or the police department. V1 stated V8 was not sent home at that time. The only documentation of this incident is the 02/20/20 written statement per V9. This document details that V8 was yelling at R3. The document states, in part; V8 said very hurtful things that even hurt my feelings. 2. The March, 2020 physician's orders [REDACTED]. The 01/20/20 Minimum Data Set (MDS) documents R7 has a Brief Interview for Mental Status (BIMS) of a 11 which indicates R7 is moderately cognitively impaired. On 03/11/20 at 2:30pm V5 (Registered Nurse) stated she witnessed an incident on 03/08/20 when she was working the 2:00pm - 10:00pm shift. She over heard V7 (CNA) reprimanding R7 for having an incontinent brief on the bathroom floor. She overheard V7 telling R7 that since she had made the mess she had better get in there and clean it up. V5 stated that V7 was harshly speaking. V7 left R7's room and then V5 stated she went into her room. When V7 saw that she had gone into the room to speak with R7, V7 came back into the room and started cleaning up the bathroom. V5 stated she did not say anything to V7. Instead, she told her nurse V6 (Licensed Practical Nurse/LPN). V5 stated she went outside for a break and sent a test message from her cellular phone to V1 at 4:05pm detailing the incident that V7 was reprimanding R7 and was harshly speaking. V5 stated she informed V1 that she did tell V6 who in turn said she would let V4 know as well. After this, she received a test message from V6 at 4:08pm that she had informed V4 (CNA Supervisor). V5 stated she let V6 know that she had informed V1 that V7 doesn't need to talk to anybody that way. V5 stated that R7 is alert, but confused at times. On 03/12/20 at 7:00am, V1 stated she did receive a text message from V5 on 03/08/20 at 4:06pm. V5 reported the incident which stated V7 was reprimanding R7 for having her incontinent brief on the floor and was telling her to clean it up in a harshly speaking tone. V1 stated she sent a text message back asking who the resident was and if V7 needed to be sent home. V5 responded that she told V6 who was to tell V4. V1 stated when V5 did not respond back regarding if V7 should be sent home she felt this was not an allegation of abuse. She felt it was more of a personal problem between the two staff who have had issues in the past. V1 stated she did not investigate this incident but can provide a copy of the text messages that she has kept on her phone. This is the only documentation of the incident provided. The Facility's Freedom from Abuse, Neglect, and Exploitation Policy states (Revised 09/25/18): E. Investigation: The Administrator or designee will begin the investigation immediately upon identification of alleged abuse. A root cause investigation and analysis will be completed. Additional Investigation Protocols: -While investigation is being conducted, accused individuals employed by Facility will be immediately suspended pending investigation. The Administrator will keep the resident or his/her resident representative informed of the progress of the investigation. The results of the investigation will be recorded and attached to the report. The administrator or designee will complete a copy of the investigation materials. The Administrator or designee will inform the resident and/or his/her representative of the findings of the investigation and corrective action taken. Inquiries made concerning abuse reporting and investigation must be referred to the Administrator or Designee. G. Reporting and response, Internal Reporting: a. Employees must always report any abuse or suspicion of abuse immediately to the Administrator. b. The Administrator, will involve key leadership personnel as necessary to assist with reporting, investigation and follow up. c. The Administrator or designee will report to the Medical Director. |
| F 0609<br><br>**Level of harm** - Minimal harm or potential for actual harm<br><br>**Residents Affected** - Few | **Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.**<br><br>Based on record review and interview the facility failed to identify a situation as an allegation of verbal abuse for 2 of 3 residents (R3, R7) reviewed for abuse in the sample of 11. The Findings Include: 1. On 03/11/20 at 7:00am, V1 (Administrator) stated that V9 (Certified Nurse Aide/CNA) and V4 (CNA Supervisor) came to her office on 02/20/20 regarding an incident that V9 wanted to report. V9 had an audio recording of V8 (CNA) speaking harshly and inappropriate to R3. V9 gave her a written statement of the incident as well. V1 stated she did not feel what she heard on the recording was verbal abuse and was not informed by anyone that they were alleging verbal abuse. She did not investigate this or report it to the Illinois Department of Public Health (IDPH). A hand written document dated 02/20/20 and signed by V9 details that V8 was yelling at R3. The document states, in part; V8 said very hurtful things that even hurt my feelings. This is the only documentation of the incident. 2. On 03/12/20 at 7:00am, V1 stated she received a text message from V5 on 03/08/20 at 4:06pm. V5 reported she over heard V7 (CNA) reprimanding R7 for having an incontinent brief on the bathroom floor. She overheard V7 telling R7 that since she had made the mess she had better get in there and clean it up. V5 stated that V7 was harshly speaking. V1 stated she sent a text message back asking if V7 needed to be sent home. V5 responded that she told V6 (Licensed Practical Nurse/LPN) who was to tell V4. V1 stated when V5 did not respond back regarding if V7 should be sent home she felt this was not an allegation of abuse. V1 stated she did not investigate this incident but can provide a copy of the text messages that she has kept on her phone. This is the only documentation of the incident that can be provided.<br>The Facility's Freedom from Abuse, Neglect, and Exploitation Policy (Revised 9/25/18) states, in part: It is the policy of the Facility that each resident will be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this policy. Abuse is defined as the willful infliction of injury, unreasonable confinement intimidation, or punishment with resulting physical harm, pain or mental anguish. Abuse also includes the deprivation by an individual, including a caretaker, of goods or services that are necessary to attain or maintain physical, mental, and psychosocial well being. Instances of abuse of all residents, irrespective of any mental or physical condition, cause physical harm, pain or mental anguish. It includes verbal abuse, sexual abuse, physical abuse, and mental abuse including abuse facilitated or enabled through the use of technology. Verbal abuse may be considered to be a type of mental abuse. Verbal abuse includes the use of oral, written, or gestured communication, or sounds, to residents within hearing distance, regardless of age, ability to comprehend, or disability. Examples of mental and verbal abuse include, but are not limited to: Harassing a resident. Mocking, insulting, ridiculing. Yelling or hovering over a resident, with the intent to intimidate. Threatening residents, including but limited to, depriving a resident of care or withholding a resident from contact with family and friends; and Isolating a resident from social interaction or activities. Policy further documents; E. Investigation: It is the policy of the Facility that reports of abuse (mistreatment, neglect, or abuse, including injuries of unknown source, exploitation and misappropriation of property) are promptly and thoroughly investigated. The investigation is the process used to try to determine what happened. The Administrator or designee will begin the investigation immediately upon identification of alleged abuse. |
| F 0610<br><br>**Level of harm** - Minimal harm or potential for actual harm<br><br>**Residents Affected** - Few | **Respond appropriately to all alleged violations.**<br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**<br>Based on record review and interview the facility failed to initiate a thorough investigation for an allegation of verbal abuse for 2 of 3 residents (R3, R7) reviewed for abuse in the sample of 11. The Findings Include: 1. The March, 2020 physician's orders [REDACTED]. The 01/15/20 Minimum Data Set (MDS) documents R3 has a Brief Interview for Mental Status (BIMS) of a 1 which indicates R3 is severely cognitively impaired. On 03/16/20 at 3:33pm,V9 (Certified Nurse Aide/CNA) stated she was working the night shift on 02/20/20 and witnessed V8 (CNA) yelling at R3 and speaking in a hateful manner. V9 stated she did not report this to V1 (Administrator) at that time. Instead, she decided to tell V4 (CNA Supervisor) when she came to work at 6:00am that day. On 02/20/20 around 1:20pm, she and V4 went to V1's office to play an audio recording of the incident. V9 stated she also gave V1 a written statement of the event. On 03/11/20 at 7:00am, V1 stated V9 and V4 did come to her office on 02/20/20 and she and V2 (Director of Nurses) listened to the audio recording of V8 speaking to R3. She did not feel it was abuse. V8 is hard of hearing and wears hearing aids. Her voice is gruff and she speaks loud due to her hearing problem. People interpret her differently even though she does not mean it. All the staff know they are to |

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| F 0610<br><br>**Level of harm** - Minimal harm or potential for actual harm<br><br>**Residents Affected** - Few | (continued... from page 2)<br>notify me immediately if they feel something is abuse. V9 did give her a written statement of the event. V1 stated she did not investigate this as abuse and no one told her they were alleging abuse. V1 stated she does not have an investigative file on this incident. The only documentation provided by V1 of this incident is the written statement dated 02/20/20 per V9. The document states, in part; V8 said very hurtful things that even hurt my feelings. Its two in the morning and your screaming for no reason. Your moms dead, your dads dead. 2. The March, 2020 physician's orders [REDACTED]. The 01/20/20 Minimum Data Set (MDS) documents R7 has a Brief Interview for Mental Status (BIMS) of a 11 which indicates R7 is moderately cognitively impaired. On 03/11/20 at 2:30pm V5 (Registered Nurse) stated she witnessed an incident on 03/08/20 when she was working the 2:00pm - 10:00pm shift. She over heard V7 (CNA) reprimanding R7 for having an incontinent brief on the bathroom floor. V7 was telling R7 that since she had made the mess she had better get in there and clean it up. V5 stated that V7 was harshly speaking. V5 stated she did not say anything to V7. Instead, she told her nurse V6 (Licensed Practical Nurse/LPN). She then went outside and sent a test message from her cellular phone to V1 at 4:05pm detailing the incident. V5 stated that R7 is alert, but confused at times. On 03/12/20 at 7:00am, V1 stated she received a text message from V5 on 03/08/20 at 4:06pm. V5 reported she over heard V7 (CNA) reprimanding R7 for having an incontinent brief on the bathroom floor. She overheard V7 telling R7 that since she had made the mess she had better get in there and clean it up. V5 stated that V7 was harshly speaking. V1 stated she sent a text message back asking if V7 needed to be sent home. V5 responded that she told V6 who was to tell V4. V1 stated when V5 did not respond back regarding if V7 should be sent home she felt this was not an allegation of abuse. She felt it was more of a personal problem between the two staff who have had issues in the past. V1 stated she did not investigate this incident but can provide a copy of the text messages that she has kept on her phone. This is the only documentation of the incident that can be provided. The Facility's Freedom from Abuse, Neglect, and Exploitation Policy states (Revised 09/25/18) : E. Investigation: It is the policy of the Facility that reports of abuse (mistreatment, neglect, or abuse, including injuries of unknown source, exploitation and misappropriation of property) are promptly and thoroughly investigated. The investigation is the process used to try to determine what happened. The Administrator or designee will begin the investigation immediately upon identification of alleged abuse. A root cause investigation and analysis will be completed. The information gathered is given to administration. |
| F 0755<br><br>**Level of harm** - Minimal harm or potential for actual harm<br><br>**Residents Affected** - Few | **Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.**<br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**<br>Based on observation, record review and interview the facility failed to properly store, label and dispose of medications and failed to supervise residents while taking their medications for 3 of 3 residents (R4, R5, R6) reviewed for medication administration in the sample of 11. The Findings Include: 1. On 3/11/20 at 2:00pm, R4 stated several months ago V36 (Family) brought in a prescription pain cream from home. The cream belonged to another family member. R4 stated the facility told V36 she could not keep the medication in her room because it did not belong to her. R4 stated she did tell V13 (CNA) she could try the cream because she was aware that she hurts. V13 did try the cream once when V36 was in the room. On 03/11/20 at 7:00am, V1 (Administrator) stated an investigation was started on 08/16/19 regarding a prescription cream being left in R4's room by V36. During the investigation she discovered that V36 had asked V27 (Previous Director of Nurses) if she could try this medication on R4 to see if it would help with her pain. V27 did tell V36 it would be ok as long as she removed the person's name from the label since it was not prescribed to R4. V1 stated she was not aware of this until V12 (Previous Director of Plant Operations) started an investigation and involved the Facility's Board of Directors. V1 stated a thorough investigation was done. V27 suspended herself and V13 was given a written warning. R4's 01/22/20 Minimum Data Set (MDS) documents she has a Brief Interview for Mental Status (BIMS) of a 14 which indicates she is cognitively intact. 2. On 03/16/20 at 1:00pm, R6 stated that she recently got choked when she was taking her Potassium tablet. It is large and difficult to swallow. R6 stated the nurses usually cut the tablet in half, but that day it was whole. A nurse had left her cup of medications in the room and she took them with no one watching. R6 stated when she got choked she pushed her call light and the staff came to help. She coughed up a large pill that had blood on it. The nurse called V35 (Physician) who ordered hot tea and changed her Potassium to a capsule that is easier to swallow. R6 stated her throat was scratchy for a few days and she was hoarse. The 03/02/20 Progress Note per V18 (Registered Nurse/RN) documents at 7:20am, she was called to R6's room and upon entry to the room found her coughing and spitting out a large amount of phlegm. Unable to talk and was pointing at her neck/throat area. Due to her size she was unable to reach around R6 to provide the [MEDICATION NAME] Maneuver and back blows were given. R6 coughed up a big chunk of something covered in bloody phlegm. She began talking and her voice was very hoarse and was tearful. R6 stated, That was scary. The notes state that R6 said she choked on a big potassium tablet. V35 was notified and orders were received to provide hot tea before breakfast.<br>R6 stated the nurses do at times leave her medications in her room without watching her take them. A few days ago, her cup of evening medications were left on her table and she had forgotten to take them. When she went to pick up the cup of pills, it spilled on the floor. V15 (Licensed Practical Nurse/LPN) was the nurse working and she had brought the pills to her room earlier. V15 looked for the pills on the floor but was only able to find three of four pills she had dropped. One was her [MEDICATION NAME] and two white pills which V15 found and gave to her from off the floor. V15 informed her the missing medication was her sleep aid and went and got her another one. On 03/16/20 at 1:10pm, V21 (Housekeeping) assisted in looking for the missing medication on the floor in R6's room. R6 stated she felt it was likely under her lift chair. V21 was able to easily find a green and white capsule under the left side of R6's lift chair. On 03/16/20 at 1:20pm, V3 (Assistant Director of Nurses) was informed of the capsule that was found under R6's chair and what R6 had reported regarding her medications being dropped. V3 provided a copy of R6's March, 2020 Controlled Drug Receipt/Record/Disposition Form for [MEDICATION NAME] 15 milligrams (mg). The document states R6 receives [MEDICATION NAME] 15mg orally daily at bedtime. The Form documents that V15 signed out a [MEDICATION NAME] 15mg on 03/14/20 at 9:00pm and wrote dropped on floor.<br>Another [MEDICATION NAME] 15mg was signed out by V15 on 03/14/20 at 10:00pm. There is no documentation regarding that this lost medications was found, reported or reconciled by two nurses. The March, 2020 Medication Administration Record [REDACTED]. The MAR indicated [REDACTED]. R6's 03/03/20 Minimum Data Set (MDS) documents she has a Brief Interview for Mental Status (BIMS) of a 15 which indicates she is cognitively intact. 3. On 03/16/20 at 2:00pm, R5 stated that she knows what medications she takes and sometimes the nurses will leave her medications in the room. R5 stated recently, V17 (Licensed Practical Nurse/LPN) brought her morning medications to her room and she told V17 to leave them. When she looked at the six pills in the medication cup, she could not identify five of the pills. She knew she was to get a Vitamin D and a [MEDICATION NAME] pill and only recognized the [MEDICATION NAME]. She went to the nurse's station to ask the nurse what was in the cup. V17 had already left for the day and another nurse was trying to help her. That nurse informed her that they were out of her Vitamin D dose so they gave her five tablets instead to equal the ordered dose. R5's 01/09/20 Minimum Data Set (MDS) documents she has a Brief Interview for Mental Status (BIMS) of a 15 which indicates she is cognitively intact. The March, 2020 physician's orders [REDACTED]. On 03/16/20 at 2:30pm, V3 stated she is aware of the day that R5 inquired about the medications she could not identify. V3 stated they found out that five Vitamin D tablets from stock were given instead of her usual Vitamin D. V3 stated medications should not be left in a resident's room and the nurses are to watch the resident take the medication. On 03/16/20 at 4:00pm, V1 (Administrator) stated medications from home are not to be left in a resident's room and should not be used if not prescribed for the resident. The nurses are to watch the residents take their medications and should not be left in a residents room. If a medication is lost the nurses are to look for the medication. If unable to be found, proper reporting and documentation must be done. Narcotic disposal and/or disposition must be reconciled by two nurses. V1 stated the Facility's policy regarding disposal of controlled medication is not correct. A liquid chemical is used to dispose of the medications and never placed in the trash. The Facility's (Revised 2/22/2016) Medication policy states: -All medications shall be given only upon the written, facsimile or electronic order of a licensed prescriber. -Administration shall be from the original containers; container shall be labeled with the name of the resident the dosage of the medication, route to be given and the time of administration. -Medications shall be administered as soon as possible after doses are prepared and shall be administered by the same person who prepared the doses for administration. -Each dose administered shall be properly recorded in the clinical record Medication Administration Record [REDACTED]. -Self-administration of medication shall be permitted only upon the written order of the licensed prescriber. Residents who wish to self-administer medications will be assessed on admission, quarterly, annual and on recognition by staff of a significant change. -Destruction of controlled medication shall be done by 2 nurses preferably |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | **145722** | A. BUILDING _____ B. WING _____ | **03/16/2020** |

| NAME OF PROVIDER OF SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP |
|---|---|
| **UNITED METHODIST VILLAGE, NORTH CAMPUS** | **2101 JAMES STREET LAWRENCEVILLE, IL 62439** |

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) |
|---|---|
| F 0755<br><br>**Level of harm -** Minimal harm or potential for actual harm<br><br>**Residents Affected -** Few | (continued... from page 3)<br>in front of the camera at the nurse's station. The medication will be removed from its packaging and placed in a container were nonedible substance will be added or H2O will be added to facilitate dissolving of medications in pill form. After medication has dissolved it will be placed in a nondescript bag and placed discreetly in the trash to be discarded. Record will be kept for any destroyed medications. |