STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145404	A. BUILDING _____ B. WING _____	**08/07/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
FARMINGTON COUNTRY MANOR	**701 SOUTH MAIN STREET FARMINGTON, IL 61531**

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 0602 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Protect each resident from the wrongful use of the resident's belongings or money.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, and record review, the facility failed to prevent medication diversion of eight [MEDICATION NAME] pills by an employee for one (R1) of four residents reviewed for controlled medications in a sample of six. Findings include: Facility Abuse Prevention Program, dated 1/1/16, documents Our residents have the right to be free from abuse, neglect, misappropriation of resident property, corporal punishment and involuntary seclusion. Our policy is committed to protecting our residents from abuse by anyone including, but not necessarily limited to: facility staff. Facility Reporting Abuse to Facility Management policy, dated 1/1/16, documents Our facility does not condone resident abuse by anyone, including staff members. To help with recognition of incidents of abuse, the following definitions of abuse are provided: 2.h. 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. Facility Incident Report, dated 4/8/20, regarding R1 documents On 4/8/20 (V10 LPN-Licensed Practical Nurse) came on duty and counted narcs (narcotics) with (V9 LPN) and the count was ok (per narc sheet). Then it was noticed that (R1) had 9 [MEDICATION NAME] on 4/7/20 along with another 30 [MEDICATION NAME] (39). One [MEDICATION NAME] was given on 4/7/20 and that would leave 8 [MEDICATION NAME] left on one card along with another 30 [MEDICATION NAME] card (38). The card of 8 [MEDICATION NAME] and the narc sheet was missing from the box and narc book. Reported to (V2 DON) and an immediate investigation by (V2) DON of the medication cart, staff, and narcotic book. V9 LPN called and asked to take a drug test. (Local) police department, (state) department, and complaint filed (Department of Professional Regulations). Because V9 failed to respond for a drug test her employment was terminated. Police Report, dated 4/9/20, documents Suspect/Offender (V9 LPN) offenses are Controlled substance: Unlawful/Possession and Theft: Under $500; general property- stolen 8 pills of [MEDICATION NAME]-Acet ([MEDICATION NAME]) 5-325mg (milligram) and completed controlled substance proof of use form. Police Report, dated 4/10/20, documents (V9 LPN) was issued two notice to appear forms for Possession of a Controlled Substance and Theft. V9 LPN Employee file documents an employee start date of 8/20/19. A signed facility Employee Acknowledgement of Receipt of Employee Handbook form, dated 8/19/10, documents I have received a copy of (facility) drug and alcohol free workplace policy contained in the employee handbook. I acknowledge that I may be required to submit to, and that I agree to submit to, drug and/or alcohol testing. I also understand that my failure to comply with this policy, and my failure to pass or refusal to submit to drug and/or alcohol testing may result in disciplinary action up to and including termination. Facility Employee Warning Report, dated 4/8/20, documents Type of Violation- narcotic count not correct. 4/8/20 at 7:05am narcotic count not correct, called (V9) at 7:05am and 7:11am and told to come in for drug testing ASAP (as soon as possible) and (V9) did not show up. On 4/8/20 called (V9) at 8:27am and (V9) did not answer, no voicemail available, and texted her and ask her if she was coming in or what. Suspension until investigation done due to narcotic count discrepancy. Facility Payroll Change Notice for (V9) documents Last day worked 4/8/20 and terminated 4/9/20 because she did not show up to do a drug test or call to explain herself to supervisor. V9 clock in/out for facility payroll indicates V9 worked 4/7/20 from 10pm until 4/8/20 6:15am. On 8/6/20 at 9:35am, V1 Administrator stated (R1) had 8 pills of [MEDICATION NAME] missing, we contacted (V9 LPN) who was the nurse that worked the night before and she wouldn't do a drug test. We reported the incident to (state), Illinois Dept. Of Professional Regulations (IDPFR), and the police. She was terminated for not submitting to the drug test. We had a card of 30 and a card of 8 [MEDICATION NAME]. The card of 8 went missing. I just got a report that IDPFR is investigating this incident. My DON (Director of Nursing) did the investigation into this. On 8/6/20 at 10:05am, V2 DON stated For (R1's) missing [MEDICATION NAME] the computer tracks the narcotics also. You have to put in to the computer the amount of medications remaining along with document on the paper narcotic count log. There was a card of 8 [MEDICATION NAME] missing after (V9 LPN) worked. (V10 LPN) had checked the narcotics log with (V9) at change of shift but the whole sheet counting the [MEDICATION NAME] along with the [MEDICATION NAME] pills were missing so there was no way she could determine the count was off at that time. (V10) came about noticing the discrepancy when she went to give (R1) her [MEDICATION NAME] and the count was off from the paper sheet and the computer record. (V9) was the nurse that worked 10pm-6am. I called (V9) and told her she needed to submit a drug test and she stated she was tired and going to bed. I called and texted her to come in a few more times and she never responded. After 2 days went by she wanted to submit a drug test but we had already termed her because there are medications you can take that flush your system out in 48 hours. Anyone that has controlled medications has a pink sheet that tracks and the computer tracks the quantity remaining. I have put a narcotic monitoring sheet in place for now since the medication incident.

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