STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145702	A. BUILDING _____ B. WING _____	09/24/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
FAIR OAKS REHAB & HEALTHCARE	1515 BLACKHAWK BOULEVARD SOUTH BELOIT, IL 61080

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 observation, interview, and record review the facility failed to prevent the misappropriation of resident medications for 3 of 3 residents (R1, R2, R3) reviewed for theft in the sample of 3. The findings include: R1's nursing notes document she was admitted on [DATE], then re-admitted on [DATE] with multiple [DIAGNOSES REDACTED]. The September 2020 MAR (Medication Administration Record) shows R1 had a 9/10/20 order for [MEDICATION NAME] 50 mg 1 tablet by mouth every 8 hours as needed for pain. The pharmacy delivery receipt shows on 9/12/20, 30 tablets were delivered to the facility and signed for by V2 DON (Director of Nursing). The MAR indicated [REDACTED]. On September 22, 2020 at 11:00 AM, V2 said she received a call on 9/14/20 at approximately 4:00 AM and was informed by the (former) ADON (Assistant Director of Nurses) R1 was missing her [MEDICATION NAME] medication card. V2 said the medication and the sign out sheet were both missing. She said after a long search, the empty medication card was found upside down and tucked in the back of the medication cart, there were at least 26 tablets missing from the card. The sign out sheet was never found. 2. R2's face sheet documents she was admitted on [DATE] with a fractured left arm. The September MAR indicated [REDACTED]. On 9/22/20 at 11:00 AM, V2 said the pharmacy delivered 30 tablets on 9/10/20. V2 said on 9/14/20 the medication card and the sign out sheet were missing. The medication card would have had 14 tablets left. V2 said a search of the nurses station and medication carts was conducted, and the empty [MEDICATION NAME] card was found in the shredder box. The sign out sheet has not been found. The September MAR indicated [REDACTED]. 3. R3's face sheet documents she was admitted to the facility on [DATE] with a right forearm fracture. The August 2020 MAR indicated [REDACTED]. The pharmacy delivery sheet for 9/5/20 shows 30 tablets of [MEDICATION NAME] 50 mg were delivered to the facility. The September MAR indicated [REDACTED]. On 9/22/20 at 11:30 AM, V2 said a nurse attempted to give R3 her pain medication and he was not able to find the card or the sign out sheet. . V2 said an audit and search was conducted but could not find any of the missing medication for R1, R2 or R3. On 9/23/20 at 11:20 PM, V6 LPN (Licensed Practical Nurse) said he was working on 9/14/20 and R2 requested a pain medication. He attempted to find the card in the medication cart and none was found. V6 said he called the pharmacy to order the med and was informed a full card had just been delivered. After searching the cart again, he tried to contact the V2 but was unsuccessful. V6 said he then called the ADON at the time to inform her of missing narcotic medication. The facility has 3 medication carts, each cart has a push lock to lock all of the drawers in the cart. Each cart has a locked drawer for controlled medications and narcotics. Each medication card has a sign out sheet from the pharmacy, and nurses sign out each individual pill as it is given. The facility's 11/2018 policy for Abuse, Prevention and prohibition defines misappropriation of resident property as the deliberate misplacement, exploitation, or wrongful, temporary or permanent use of a resident's belongings or money without the resident's consent. The facility prohibits misappropriation of resident property.
F 0755 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to reconcile controlled medications for 3 of 3 residents (R1, R2, R3) reviewed for pharmacy services. The findings include: R1's nursing notes document she was admitted on [DATE], then re-admitted on [DATE] with multiple [DIAGNOSES REDACTED]. The September 2020 MAR (Medication Administration Record) shows R1 had a 9/10/20 order for [MEDICATION NAME] 50 mg 1 tablet by mouth every 8 hours as needed for pain. The pharmacy delivery receipt shows on 9/12/20, 30 tablets were delivered to the facility and signed for by V2 DON (Director of Nursing). The MAR indicated [REDACTED]. On September 22, 2020 at 11:00 AM, V2 said she received a call on 9/14/20 at approximately 4:00 AM and was informed by the (former) ADON (Assistant Director of Nurses) R1 was missing her [MEDICATION NAME] medication card. V2 said the medication and the sign out sheet were both missing. She said after a long search, the empty medication card was found upside down and tucked in the back of the medication cart, there was at least 26 tablets missing from the card. The sign out sheet was never found. R2's face sheet documents she was admitted on [DATE] with a fractured left arm. The September MAR indicated [REDACTED]. On 9/22/20 at 11:00 AM, V2 said the pharmacy delivered 30 tablets on 9/10/20. V2 said on 9/14/20 the medication card and the sign out sheet were missing. The medication card would have had 14 tablets left. V2 said a search of the nurses station and medication carts was conducted, and the empty [MEDICATION NAME] card was found in the shredder box. The sign out sheet has not been found. The September MAR indicated [REDACTED]. R3's face sheet documents she was admitted to the facility on [DATE] with a right forearm fracture. The August 2020 MAR indicated [REDACTED]. The pharmacy delivery sheet for 9/5/20 shows 30 tablets of [MEDICATION NAME] 50 mg were delivered to the facility. The September MAR indicated [REDACTED]. On 9/22/20 at 11:30 AM, V2 said a nurse attempted to give R3 her pain medication and he was not able to find the card or the sign out sheet. . V2 said an audit and search was conducted but could not find any of the missing medication for R1, R2 or R3. The facility has 3 medication carts, each cart has a push lock to lock all of the drawers. Each cart has a locked drawer for controlled medications and narcotics. The controlled medication cards have a sign out sheet, and nurses sign out each pill as it is given. The narcotic book has a Shift change accountability record sheet and is signed by the oncoming and out going nurses. On 9/22/20 at 11:00 AM, V2 said pharmacy delivers medications on the night shift. The nurse on duty and the driver sign together for the controlled medications. The controlled medication cards come with a count sheet that shows the resident name, medication and number of pills in the card. The nurse puts the card in the double locked medication cart and the sign out sheet goes into the narcotic book. V2 said the nurse must add the medication onto the master log. The master log sheet shows the number of controlled items in the cart. V2 said this count should be verified each shift by 2 nurses, and both sign the accountability record when the count is accurate and complete. On 9/23/20 at 11:20 PM, V6 LPN said on the night of 9/13/20 he counted the narcotics with V5 RN (Registered Nurse) and the count was accurate. V6 said there is no way to keep track of cards themselves in the medication cart. If someone takes the medication and the sign out sheet, the next nurse would not know. V6 said he feels the master count log is not accurate and has seen the log count changed or corrected to match what is in the cart. V6 said on the night of 9/13/20, R2 had requested a pain medication and when he attempted to find the medication in the cart it was gone, along with the sign out sheet. He called the pharmacy for a refill, and was told by pharmacy a card had been sent with the last week. V6 said at that time he attempted to call V2 and could not get a hold of her, so he called the ADON. V6 said when an audit was done on the medication cart, 3 residents had controlled medications missing. On 9/22/20 at 2:00 PM, V5 said she worked on 9/13/20 from 7:00 AM to 11:00 PM. She was relieved by V6, and they conducted a narcotic count. V5 said part of the count is the master log listing the number of control items with count sheets. The number should match what is in the medication cart, but it is not always correct, and the number just gets changed to match the actual inventory. The master log of controlled medication sheets for September 2020 were reviewed. The

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

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.

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F 0755 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 1) log includes the number of medication sheets, date/time and a column to indicate if a medication is added or subtracted from the count. The resident and medication should be listed with the number of cards, and if the medication was added as new or refill, or if the card was removed due to expiration, discharged , empty, or discontinued. The nurse must sign and put the number of ending sheets and medications. The September log shows incomplete information for resident names, multiple names are placed into 1 entry and are illegible. On 9/3/20 and 9/5/20 the count is changed without resident information or medications removed. The 9/10/20 entry shows the count reduced from 25 to 21 without resident or medication information. On 9/4/20 the log show a +1 and -1 and the count remained the same, no resident information entered. On 9/10/20 the count was lowered by 4, and no medication or resident information was logged. On 9/12/20 at 2200 the count was 19, V5 documents she removed a card for R1 and the count was 20 instead of 18. On 9/13/20 at 6:00 AM, the count remained at 20. On 9/13/20 at 2:00 PM, the log shows 2 resident names and 2 medication with a -1 for quantity removed, and the count was adjusted to 17. On 9/22/20 at 11:15 AM, V2 said when medications are added or removed from the cart, it should be documented on the master log with all of the resident and medication information. The count should be adjusted, and at shift change the nurses should be checking and matching the number of medications in the cart to what the master log shows. The count should not just be adjusted or changed without documentation. On 9/22/20 at 9:30 AM, V3 RN said each controlled medication comes with a sign out sheet and each pill should be documented as it is given. In her cart, V3 pulled 2 cards of R1's [MEDICATION NAME] 5 mg tablets. One card had 4 pills and the second card had 28 pills. The second card showed the pills in the 27 and 28 bubbles to be larger and thicker than the other 26 pills in the card. V3 said someone had removed 2 pills from the second card instead of using up from the first card. V3 said for the ease of counting, 2 pills were taken from the first card and taped into the second card to keep the count full on the second card. V3 said it was all the same medication and was not an issue. V4 LPN said she has seen controlled medications taped into the cards. V4 said controlled medications should not be removed and taped back into a card, and different pills should not be taped into a card. On 9/22/20 at 11:30 AM, V2 said no controlled medications should be removed and taped back into any medication card, or into a different card. The facility's January 2017 policy for controlled substances documents controlled substances are subject to special handling, storage, disposal and record-keeping requirements. The facility will maintain compliance with these special provisions. 3. .A physical inventory of medication will be made at the change of each nursing shift. Shift Verification Count sheets/packages shall be completed at the change of each shift. 4. The persons performing the inventory will sign to verify that the inventory was done, All controlled substances are to be counted every shift. Both nurses will sign ton the narcotic sign in and out sheet that the count was completed. 5. Any discrepancy in the inventory of a controlled substance is to be reported to the Director of Nurses immediately.