STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145239	A. BUILDING _____ B. WING _____	08/20/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
CORNERSTONE REHAB & HC	5533 NORTH GALENA ROAD PEORIA HEIGHTS, IL 61614

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** - Some	**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 record review and interview, the facility failed to ensure misappropriation of resident property did not occur for 15 of 16 residents (R2, R4, R10, R14-R25) reviewed for medication diversion, in a sample of 25. Findings include: The facility policy, titled Abuse Prevention Program (dated 11/28/16), documents This facility affirms the right of our residents to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined below. The policy then 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. An Incident Report, dated 7/29/20, documents V3 (Licensed Practical Nurse/MDS Coordinator) reported on 7/28/20 that during the shift change controlled substance count, it was noted that 37 tablets of [MEDICATION NAME]-[MEDICATION NAME] 5/325 mg were unaccounted for belonging to R2. According to the Incident Report, the facility Administrator at that time (V17) was notified and an investigation was immediately initiated. The Incident Report documents, Per interview and written statement, (V3) reports that controlled substance count was completed per norm during shift change with off-going day shift nurse (V4 - Registered Nurse). The narcotic box and corresponding controlled substance proof of record count were correct. (V3) then noted a controlled substance proof of use record inadvertently placed in the MAR (Medication Administration Record) for said cart, not in the typical binder with all of the controlled substance proof of use records. (V3) then noted that the corresponding card of [MEDICATION NAME]/[MEDICATION NAME] was not in the narcotic lock box or unable to be located in the (medication) cart or (medication) room. Administrator was notified immediately. Per controlled substance proof of use record, 37 tablets were unaccounted for. The Incident Report then documents, During investigation facility worked alongside (consulting pharmacy) to obtain controlled substance reports for all controlled substances dispensed over the last 90 days. It was noted that not all controlled substance proof of use records were able to be located in medical records. The Incident Report fails to identify what other controlled substances were unaccounted for, or for whom, after the facility's reconciliation. The Incident Report stated, In conclusion, diversion is suspected but unable to be confirmed. No one suspect was able to be pin-pointed with evidence presented. On 8/18/20 at 12:48 pm, V11 (Corporate Nurse) stated she assisted V15 (Consulting Pharmacist) on 7/30/20 in review of all delivered controlled substances over the last 90 days per the delivery requisitions, and compared those to the narcotic reconciliation forms and proof of destruction forms in the facility. V11 stated they determined there was definitely a problem, as well over 1000 tablets of narcotics were unaccounted for and the police were notified. On 8/18/20 at 10:30 am, V3 (Licensed Practical Nurse/MDS Coordinator) stated he did report R2's [MEDICATION NAME]/[MEDICATION NAME] missing on 7/28/20 and he provided information to the Administrator at that time, V17. V3 stated it was determined that the medication had likely been diverted, but the facility could no determine who took them. V11 provided further documentation of her investigation findings, which identified all residents whose controlled substances were determined missing/unaccounted for over the last 90 days, the quantity and date they were dispensed to the facility. The documentation identifies the following: 1. R2 - [MEDICATION NAME]/[MEDICATION NAME] 5/325 mg, quantity #45, dispensed to facility on 5/11/20; [MEDICATION NAME]/[MEDICATION NAME] 5/325 mg, quantity #30, dispensed to facility on 5/26/20; [MEDICATION NAME] 0.5 mg, quantity #30, dispensed to facility on 5/18/20; [MEDICATION NAME]/[MEDICATION NAME] 5/325 mg, quantity #30, dispensed to facility on 6/08/20; [MEDICATION NAME]/[MEDICATION NAME] 5/325 mg, quantity #30, dispensed to facility on 7/08/20; [MEDICATION NAME]/[MEDICATION NAME] 5/325 mg, quantity #30, dispensed to facility on 7/09/20; [MEDICATION NAME]/[MEDICATION NAME] 5/325 mg, quantity #30, dispensed to facility on 7/17/20; [MEDICATION NAME]/[MEDICATION NAME] 5/325 mg, quantity #45, dispensed to facility on 7/22/20. 2. R4 - [MEDICATION NAME]/[MEDICATION NAME] 5/325 mg, quantity #45, dispensed to facility on 5/25/20. 3. R10 - [MEDICATION NAME]/[MEDICATION NAME] 5/325 mg, quantity #30, dispensed to facility on 5/11/20; [MEDICATION NAME]/[MEDICATION NAME] 5/325 mg, quantity #30, dispensed to facility on 6/08/20; [MEDICATION NAME]/[MEDICATION NAME] 5/325 mg, quantity #30, dispensed to facility on 7/22/20. 4. R14 - Dronabinol 2.5 mg, quantity #15, dispensed 5/15/20; [MEDICATION NAME]/[MEDICATION NAME] 5/325 mg, quantity #20, dispensed 5/15/20. 5. R15 - [MEDICATION NAME]/[MEDICATION NAME] 7.5/325 mg, quantity #30, dispensed to facility on 5/19/20; [MEDICATION NAME]/[MEDICATION NAME] 7.5/325 mg, quantity #30, dispensed to facility on 6/16/20; [MEDICATION NAME]/[MEDICATION NAME] 7.5/325 mg, quantity #28, dispensed to facility on 7/10/20; [MEDICATION NAME]/[MEDICATION NAME] 7.5/325 mg, quantity #30, dispensed to facility on 7/17/20. 6. R16 - [MEDICATION NAME]/[MEDICATION NAME] 10/325 mg, quantity #60, dispensed to facility on 5/07/20; [MEDICATION NAME]/[MEDICATION NAME] 10/325 mg, quantity #60, dispensed to facility on 5/11/20; [MEDICATION NAME]/[MEDICATION NAME] 10/325 mg, quantity #60, dispensed to facility on 5/22/20; [MEDICATION NAME]/[MEDICATION NAME] 10/325 mg, quantity #180, dispensed to facility on 6/03/20; [MEDICATION NAME]/[MEDICATION NAME] 10/325 mg, quantity #54, dispensed to facility on 6/29/20; [MEDICATION NAME] 0.5 mg, quantity #30, dispensed 5/12/20; [MEDICATION NAME] 0.5 mg, quantity #30, dispensed 6/22/20. 7. R17 - [MEDICATION NAME]/[MEDICATION NAME] 10/325 mg, quantity #30, dispensed to facility on 5/19/20. 8. R18 - [MEDICATION NAME]/[MEDICATION NAME] 5/325 mg, quantity #60, dispensed to facility on 5/11/20; [MEDICATION NAME] 50 mg, quantity #30, dispensed 6/05/20. 9. R19 - [MEDICATION NAME]/[MEDICATION NAME] 5/325 mg, quantity #60, dispensed to facility on 5/11/20; [MEDICATION NAME]/[MEDICATION NAME] 5/325 mg, quantity #60, dispensed to facility on 7/22/20; [MEDICATION NAME] 50 mg, quantity #30, dispensed 5/18/20. 10. R20 - [MEDICATION NAME]/[MEDICATION NAME] 5/325 mg, quantity #60, dispensed to facility on 5/11/20. 11. R21 - [MEDICATION NAME]/[MEDICATION NAME] 5/325 mg, quantity #60, dispensed to facility on 5/25/20; [MEDICATION NAME]/[MEDICATION NAME] 5/325 mg, quantity #60, dispensed to facility on 6/22/20; [MEDICATION NAME]/[MEDICATION NAME] 5/325 mg, quantity #60, dispensed to facility on 7/16/20. 12. R22 - [MEDICATION NAME] 0.5 mg, quantity #30, dispensed 05/01/20; [MEDICATION NAME] 0.5 mg, quantity #30, dispensed 7/16/20. 13. R23 - [MEDICATION NAME] 0.5 mg, quantity #60, dispensed 5/12/20. 14. R24 - [MEDICATION NAME]/[MEDICATION NAME] 5/325 mg, quantity #10, dispensed to facility on 7/13/20; [MEDICATION NAME]/[MEDICATION NAME] 5/325 mg, quantity #6, dispensed to facility on 7/14/20; [MEDICATION NAME]/[MEDICATION NAME] 5/325 mg, quantity #30, dispensed to facility on 7/22/20. 15. R25 - [MEDICATION NAME] 0.5 mg, quantity #30, dispensed to facility on 7/11/20.
F 0607 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Develop and implement policies and procedures to prevent abuse, neglect, and theft.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to implement policies related to the investigating and reporting of misappropriation of resident property, for 15 of 16 residents (R2, R4, R10, R14-R25) reviewed for medication diversion, in a sample of 25. Findings include: The facility policy, titled Abuse Prevention Program (dated 11/28/16), 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 policy documents that the facility will responsible for Procedures for reporting of potential incidents of abuse, neglect, exploitation, or misappropriation of resident property. The Abuse Prevention Program documents, for Investigation Procedures, Regardless of the specific nature of the allegation (Physical, Sexual, Verbal/Exploitation/Mental, Theft or Neglect), the investigation shall consist of: A review of the initial reports; Completion of a written report on the status of the investigation of the occurrence; An

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 0607 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 1) interview with the person (s) reporting the incident; Interviews with witnesses to the incident; An interview with the resident; Where appropriate, an interview with the resident's attending physician or psychiatrist; A review of the medical records of any residents involved in the occurrence; If the accused individual is an employee, review of the personnel file to check for references, background check, and documentation of orientation and training; An interview with staff members having contact with the resident and accused individual; Where appropriate, interviews with the resident's roommate, family members, visitors or others who were in the vicinity of the incident; Interview other employees to determine if they have ever witnessed other incidents of mistreatment. The facility policy, titled Missing Controlled Substance (Revised 10/07, Reviewed 11/06/18) documents, The Administrator will be responsible for notifying the police, regulatory agencies as relevant and the Regional Director of any findings of the investigation suggestive of misappropriation of controlled substances. The policy also documents, if the controlled substance count is incorrect, The Director of Nursing will report the discrepancy to the Pharmaceutical Consultant upon verification that the count is inaccurate. An Incident Report, dated 7/29/20, documents V3 (Licensed Practical Nurse/MDS Coordinator) reported on 7/28/20 that during the shift change controlled substance count, it was noted that 37 tablets of [MEDICATION NAME]-[MEDICATION NAME] 5/325 mg were unaccounted for for R2. According to the Incident Report, the facility Administrator at that time (V17) was notified and an investigation was immediately initiated. The Incident Report documents, Per interview and written statement, (V3) reports that controlled substance count was completed per norm during shift change with off-going day shift nurse (V4 - Registered Nurse). The narcotic box and corresponding controlled substance proof of record count were correct. (V3) then noted a controlled substance proof of use record inadvertently placed in the MAR (Medication Administration Record) for said cart, not in the typical binder with all of the controlled substance proof of use records. (V3) then noted that the corresponding card of [MEDICATION NAME]/[MEDICATION NAME] was not in the narcotic lock box or unable to be located in the (medication) cart or (medication) room. Administrator was notified immediately. Per controlled substance proof of use record, 37 tablets were unaccounted for. The Incident Report then documents, During investigation facility worked alongside (consulting pharmacy) to obtain controlled substance reports for all controlled substances dispensed over the last 90 days. It was noted that not all controlled substance proof of use records were able to be located in medical records. The Incident Report fails to identify what other controlled substances were unaccounted for, or for whom, after the facility's reconciliation. The Incident Report documents, In conclusion, diversion is suspected but unable to be confirmed. No one suspect was able to be pin-pointed with evidence presented. The Incident Investigation fails to include interviews with staff, other than V3 and V4, and no resident interviews. On 8/18/20 at 12:48 pm, V11 (Corporate Nurse) stated during the course of the investigation it was determined that over the last 90 days there was definitely a problem, as well over 1000 tablets of narcotics were unaccounted for and the police were notified. On 8/19/20 at 2:55 pm, V12 (Police Sergeant) stated the facility only reported to him, on 7/29/20 that R2 was missing 37 tablets of [MEDICATION NAME]/[MEDICATION NAME]. V12 stated it was never reported to the police that numerous other controlled substances were missing from the facility and that diversion by staff was suspected. On 8/19/20 at 11:59 am, V16 (Consultant Pharmacist) stated he was unaware that the facility was missing any narcotics over the last month and nothing was reported to him as a possible/suspected diversion.
F 0608 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Develop and implement policies and procedures to ensure (1) employees report any suspicion of a crime against any resident, according to timelines; (2) post the notice of employee rights; and (3) prohibit and prevent retaliation for reporting.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to fully report investigative findings related to the misappropriation of resident property to the local police department, for 15 of 16 residents (R2, R4, R10, R14-R25) reviewed for misappropriation of resident property in a sample of 25. Findings include: The facility policy, titled Abuse Prevention Program (dated 11/28/16), 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 policy documents that the facility will be responsible for informing Law Enforcement Authorities, as soon as possible when a crime has been committed in a facility by a person other than a resident. The facility policy, titled Missing Controlled Substance (Revised 10/07, Reviewed 11/06/18) documents, The Administrator will be responsible for notifying the police, regulatory agencies as relevant and the Regional Director of any findings of the investigation suggestive of misappropriation of controlled substances. An Incident Report sent to the State Agency, dated 7/29/20, documents nursing staff noted on 7/28/20 that R2 was missing 37 tablets of [MEDICATION NAME]-[MEDICATION NAME] 5/325 mg during the routine narcotic count at shift change. The Incident Report indicates an investigation into R2's missing [MEDICATION NAME]-[MEDICATION NAME] was conducted, and the medication was determined to be unaccounted for and diversion was suspected. The Incident Report, then documents the facility did an audit of all controlled substances dispensed over the last 90 days and It was noted that not all controlled substance proof of use records were able to be located in medical records. The Incident Report summarizes, In conclusion, diversion is suspected but unable to be confirmed. No one suspect was able to be pin-pointed with evidence presented. On 8/18/20 at 12:48 pm, V11 (Corporate Nurse) stated during the course of the investigation it was determined that over the last 90 days there was definitely a problem, as well over 1000 tablets of narcotics were unaccounted for and the police were notified. On 8/18/20, V11 provided additional documentation not included in the investigation. That documentation confirmed the following finding during the facility audit of controlled medications on 7/30/20: 14 additional identified residents affected (R4, R10, R14 - R25), 1283 tablets of [MEDICATION NAME]/[MEDICATION NAME], 240 tablets of [MEDICATION NAME], 60 tablets of [MEDICATION NAME], 15 tablets of Dronabinol, and 20 tablets of [MEDICATION NAME], all controlled substances, that had been determined to be suspect of diversion over the last 90 days. On 8/19/20 at 2:55 pm, V12 (Police Sergeant) stated the facility only reported to him, on 7/29/20 that R2 was missing 37 tablets of [MEDICATION NAME]/[MEDICATION NAME]. V12 stated it was never reported to the police that numerous other controlled substances were missing from the facility and that diversion by staff was suspected.
F 0609 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to report suspected misappropriation of resident property to the State Agency, for 15 of 16 residents (R2, R4, R10, R14-R25) reviewed for missing medication, in a sample of 25. Findings include: The facility policy, titled Abuse Prevention Program (dated 11/28/16), 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 policy documents that the facility will responsible for Procedures for reporting of potential incidents of abuse, neglect, exploitation, or misappropriation of resident property and The facility must ensure all alleged violations involving mistreatment, exploitation, neglect or abuse, including injuries of unknown source, misappropriation of resident property and reasonable suspicion of a crime are reported immediately to the administrator of the facility and to other officials in accordance with State Law through established facility procedures.' The facility policy, titled Missing Controlled Substance (Revised 10/07, Reviewed 11/06/18) documents, It is the policy of this facility to prevent the loss of controlled substances and vigorously investigate incorrect inventory of controlled drugs, medications or pharmaceuticals reported by pharmacists, physicians or licensed nurses. The policy later documents, The Administrator will be responsible for notifying the police, regulatory agencies as relevant and the Regional Director of any findings of the investigation suggestive of misappropriation of controlled substances. An Incident Report sent to the State Agency, dated 7/29/20, documents nursing staff noted on 7/28/20 R2 was missing 37 tablets of [MEDICATION NAME]-[MEDICATION NAME] 5/325 mg during the routine narcotic count at shift change. The Incident Report indicates an investigation into R2's missing [MEDICATION NAME]-[MEDICATION NAME] was conducted, the medication was determined to be unaccounted for and diversion was suspected. The Incident Report, then documents, During investigation facility worked alongside (consulting pharmacy) to obtain controlled substance reports for all controlled substances dispensed over the last 90 days. It was noted that not all controlled substance proof of use records were able to be located in medical records. The Incident Report fails to identify what other controlled substances were unaccounted for, or for whom, after

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F 0609 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 2) the facility's audit. The Incident Report summarizes, In conclusion, diversion is suspected but unable to be confirmed. No one suspect was able to be pin-pointed with evidence presented. On 8/18/20 at 12:48 pm, V11 (Corporate Nurse) stated she and V17 (previous Administrator) completed a review of all controlled substances delivered over the last 90 days per the delivery requisitions, and compared those to the narcotic reconciliation forms and proof of destruction forms in the facility. V11 stated they determined there was definitely a problem, as well over 1000 tablets of narcotics were unaccounted for and the police were notified. V11 stated, this involved multiple residents and medication besides [MEDICATION NAME]/[MEDICATION NAME]. V11 agreed to provide additional information regarding the specifics identified in the investigation at that time, including each residents were affected, the medication missing, amount, and the date it was delivered to the facility. V11 was unclear as to why the additional information was not reported to the State Agency, but stated they had recently had a change in Administration. The documentation provided by V11, on 8/18/2/0, included the following information: 14 additional identified residents affected (R4, R10, R14 - R25), 1283 tablets of [MEDICATION NAME]/[MEDICATION NAME], 240 tablets of [MEDICATION NAME], 60 tablets of [MEDICATION NAME], 15 tablets of Dronabinol, and 20 tablets of [MEDICATION NAME], all controlled substances, that had been determined to be suspect of diversion over the last 90 days. All of which was not reported to the State Agency with the investigation initiated on 7/29/20 or any time thereafter.
F 0610 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Respond appropriately to all alleged violations.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to thoroughly investigate misappropriation of resident property for 15 of 16 residents (R2, R4, R10, R14-R25) reviewed for medication diversion, in a sample of 25. Findings include: The facility policy, titled Abuse Prevention Program (dated 11/28/16), 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 policy further documents that the facility will be responsible for Implementing systems to investigate all reports of possible abuse, exploitation, neglect, abuse, misappropriation of resident property; promptly and aggressively, and making the necessary changes to prevent future occurrences. The policy instructs, under Step 5. Investigation Procedures: Regardless of the specific nature of the allegation (Physical, Sexual, Verbal/Exploitation/Mental, Theft or Neglect), the investigation shall consist of: A review of the initial reports; Completion of a written report on the status of the investigation of the occurrence; An interview with the person (s) reporting the incident; Interviews with witnesses to the incident; An interview with the resident; Where appropriate, an interview with the resident's attending physician or psychiatrist; A review of the medical records of any residents involved in the occurrence; If the accused individual is an employee, review of the personnel file to check for references, background check, and documentation of orientation and training; An interview with staff members having contact with the resident and accused individual; Where appropriate, interviews with the resident's roommate, family members, visitors or others who were in the vicinity of the incident; Interview other employees to determine if they have ever witnessed other incidents of mistreatment. The policy later specifies, under Resident Protection Investigating Paths, that IF their IS a suspicion of theft involved, proceed with the investigation procedures in Step 5, interview of witnesses. The facility policy, titled Missing Controlled Substance (Revised 10/07, Reviewed 11/06/18) documents, It is the policy of this facility to prevent the loss of controlled substances and vigorously investigate incorrect inventory of controlled drugs, medications or pharmaceuticals reported by pharmacists, physicians or licensed nurses. The policy instructs staff to include in their investigation, Note and interview the last oncoming and outgoing Licensed Nurses to determine accuracy of count and circumstances surrounding count. Interview any Licensed Nurse known to work during the interim, regarding observation, administration, count verification or note of unusual circumstances surrounding the lock box or access to it. An Incident Report, dated 7/29/20, documents V3 (Licensed Practical Nurse/MDS Coordinator) reported on 7/28/20 that 37 tablets of [MEDICATION NAME]-[MEDICATION NAME] 5/325 mg were unaccounted for for R2. According to the Incident Report, the facility Administrator (V17) at that time was notified and an investigation was immediately initiated. The Incident Report documents, Per interview and written statement, (V3) reports that controlled substance count was completed per norm during shift change with off-going day shift nurse (V4 - Registered Nurse). The narcotic box and corresponding controlled substance proof of record count were correct. (V3) then noted a controlled substance proof of use record inadvertently placed in the MAR (Medication Administration Record) for said cart, not in the typical binder with all of the controlled substance proof of use records. (V3) then noted that the corresponding card of [MEDICATION NAME]/[MEDICATION NAME] was not in the narcotic lock box or unable to be located in the (medication) cart or (medication) room. Administrator was notified immediately. Per controlled substance proof of use record, 37 tablets were unaccounted for. The Incident Report then documents, During investigation facility worked alongside (consulting pharmacy) to obtain controlled substance reports for all controlled substances dispensed over the last 90 days. It was noted that not all controlled substance proof of use records were able to be located in medical records. The Incident Report summarizes, In conclusion, diversion is suspected but unable to be confirmed. No one suspect was able to be pin-pointed with evidence presented. The Incident Report fails to identify what other controlled substances were unaccounted for, or for whom, after the facility's reconciliation with the consulting pharmacy. The Incident report also fails to document interviews with any staff, other than V4 and V3, or interviews with residents. On 8/18/20 at 12:48 pm, V11 (Corporate Nurse) stated she assisted in the facility audit of all delivered controlled substances over the last 90 days, with the help of the consultant pharmacist (V15). V11 stated there was a review of all pharmacy delivery requisitions, and those were compared to the narcotic reconciliation forms and proof of destruction forms in the facility. V11 stated they determined there was definitely a problem, as well over 1000 tablets of narcotics were unaccounted for multiple other residents (not identified in the investigation). V11 stated she did interview residents potentially affected by the suspected diversion of narcotics, but that documentation was unavailable. V11 verified that the only staff statement she had was that of V3 and V4. On 8/18/20, V11 provided documentation of their findings during the controlled substance audit on 7/30/20. This included the following information: 14 additional identified residents affected (R4, R10, R14 - R25), 1283 tablets of [MEDICATION NAME]/[MEDICATION NAME], 240 tablets of [MEDICATION NAME], 60 tablets of [MEDICATION NAME], 15 tablets of Dronabinol, and 20 tablets of [MEDICATION NAME], all controlled substances, that had been determined to be suspect of diversion over the last 90 days. There was no documented evidence of any trends identified during the course of the investigation, interviews with staff that had accepted controlled substances delivered from pharmacy, or evidence that the consulting pharmacy had participated in the investigation. On 8/19/20 at 11:51 am, V15 (Consulting Pharmacist) stated he did not work with the facility to help determine if controlled substances were being diverted, as he is no longer assigned to that building. V15 referred to V16 (Consulting Pharmacist) as being assigned to that facility for all pharmaceutical needs. On 8/19/20 at 11:59 am, V16 stated he was unaware that the facility was missing any narcotics over the last month and nothing was reported to him as a possible/suspected diversion. V16 stated, due to the current pandemic, he is working remotely and not entering the facilities; however, the facility could have put in a special request and he would have been able to enter the facility to assist with a facility wide audit of controlled substances. V16 stated that part of his role at the Consultant Pharmacist is to assist in situations, such as this, and help identify a pattern to point to a specific staff member that could be taking the medications.
F 0727 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Many	**Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis.** Based on interview and record review, the facility failed to ensure a registered nurse was scheduled 8 hours per day, 7 days a week. This failure has the potential to effect all 46 residents residing in the facility. Findings include: Nursing Schedules dated 3/1/20 through 8/19/20, document the facility did not have a Registered Nurse for a minimum of 8 hours on the following dates: 4/25/20, 4/26/20, 5/9/20, 5/10/20, 5/14/20, 5/19/20, 5/23/20, 5/24/20, 6/20/20, 6/21/20, 7/4/20, 7/5/20, 7/9/20, 7/13/20, 7/14/20, 7/15/20, 7/18/20, 7/19/20, 7/27/20, 7/29/20, and 8/12/20. An email from V3 (Licensed Practical Nurse/Care Plan Coordinator) dated 8/19/20 at 12:34 p.m., states there was no registered nurse for a minimum of 8 hours per day on the following dates: 4/25/20, 4/26/20, 5/9/20, 5/10/20, 5/14/20, 5/19/20, 5/23/20, 5/24/20, 6/20/20, 6/21/20, 7/4/20, 7/5/20, 7/9/20, 7/13/20, 7/14/20, 7/15/20, 7/18/20, 7/19/20, 7/27/20, 7/29/20, and 8/12/20. On 8/19/20 at 1:36 p.m., V1 (Administrator) stated the Registered Nurse is considered the charge nurse when in the facility. V1 stated

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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 0727 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Many	(continued... from page 3) the Charge Nurse would be responsible for any issues that may arise during the shift and would also be responsible for notifying administration of any issues. V1 stated the facility does not have a policy regarding Registered Nurse coverage. An email dated 8/19/20 at 1:55 p.m., documents the facility does not have a policy regarding Registered Nurse Staffing. The email also documents that V11 (Regional Clinical Nurse) stated that when no Registered Nurse is in the building, the staff know to call her. On 8/18/20 at 12:48 p.m., V11 stated she has not been able to come to the facility because she is on her second 14 day Covid-19 travel quarantine. The Facility's Centers for Medicare and Medicaid Services Roster Matrix dated 8/19/20, documents there are 46 residents residing in the facility.
F 0755 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**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 record review and interview, the facility failed to ensure that a resident's personal supply of narcotic medication was secure and accounted for and failed to follow facility policy and procedure for missing controlled substances, for 15 of 16 residents (R2, R4, R10, R14-R25) reviewed for medication diversion in a sample of 25. Findings include The facility policy titled Controlled Substances (revised 11/02/17) documents, It is the policy of the facility that all drugs listed as schedule II drugs are subject to specified handling, storage, disposal and record keeping. The policy further documents, 2. At the time a controlled substance is delivered, the Charge Nurse and the delivery person will count the controlled substance together to verify the count. If the controlled substance count of an item being delivered is in error the nurse will note the error, notify the pharmacist, refuse delivery of the substance and reorder the prescription. 3. If the controlled substance count is correct, a control sheet for each prescription will be initiated. The policy documents, 9. Discrepancies must be reported immediately to the Director of Nursing who shall investigate as described in the Missing Controlled Substance Policy. When loss, suspected theft or an error in the administration of regulated drug occurs, a report will be filed with the Pharmacist and the Administrator. The facility policy, titled Missing Controlled Substance (Revised 10/07, Reviewed 11/06/18) documents, The Administrator will be responsible for notifying the police, regulatory agencies as relevant and the Regional Director of any findings of the investigation suggestive of misappropriation of controlled substances. The policy also documents, 4. Should the count prove to be incorrect compared to actual inventory at any time, report will be made to the Director of Nursing immediately. 5. An immediate inventory of controlled substances will be taken by the Director of Nursing and Administrator. 6. The Director of Nursing will report the discrepancy to the Pharmaceutical Consultant upon verification that the count is inaccurate. An Incident Report sent to the State Agency, dated 7/29/20, documents it was reported on 7/28/20 that 37 tablets of [MEDICATION NAME]-[MEDICATION NAME] 5/325 mg (milligrams) was unaccounted for for R2. Additionally, the Incident Report documents, During investigation facility worked alongside (consulting pharmacy) to obtain controlled substance reports for all controlled substances dispensed over the last 90 days. It was noted that not all controlled substance proof of use records were able to be located in medical records. The Incident Report summarizes, In conclusion, diversion is suspected but unable to be confirmed. A Controlled Med Investigation Timeline (no date) documents on 7/30/20 from 9:00 am - 1:00 pm, All delivered controlled substances of the last 90 days inventoried per the delivery requisition obtained by (consulting pharmacy). Discrepancies noted. 1:11 pm - Medical Director updated on confirmed discrepancies. The timeline fails to document that the facility's Pharmaceutical Consultant was notified that the facility found their controlled substance count to be inaccurate. On 8/18/20 at 10:30 am, V3 (Licensed Practical Nurse/MDS Coordinator) stated he was coming on the 6:00 pm - 6:00 am shift of 7/28/20 and completed the regular shift change narcotic count with V4 (Registered Nurse). V3 stated the narcotics in the double locked box of the medication cart matched the corresponding pink reconciliation form in the Narcotic Book. However, they found a loose narcotic reconciliation form for R2's [MEDICATION NAME]/[MEDICATION NAME] 5/325 mg quantity of 45 tablets that was delivered on 7/22/20, folded in half in the Medication Administration Record [REDACTED]. V3 stated that he and V4 could not locate the pills in the medication carts or medication room. V3 stated is was as if someone had taken R2's remaining 37 [MEDICATION NAME]/[MEDICATION NAME] tablets and attempted to hide the reconciliation form. R2's Controlled Substance Proof of Use Form, dated 7/22/20, documents R2 was given 8 doses of [MEDICATION NAME]/[MEDICATION NAME] 5/325 mg one tablet, between 7/23/20 and 7/26/20, leaving 37 tablets unaccounted for. On 8/18/20, V4 (Registered Nurse) stated the facility has the typical tracking system in place for controlled substances, where the oncoming and off-going nurse count the narcotics at shift change and make sure the count corresponds accurately with the reconciliation form in the Controlled Substance book. However, V4 stated the facility does not have a tracking system for what is delivered by the pharmacy courier, so someone could take the pink reconciliation form and the corresponding PRN (as needed) controlled substance as if it wasn't delivered in the first place. V4 stated if the resident doesn't routinely take the prescribed controlled substance, it might not be missed. On 8/18/20 at 12:48 pm, V11 (Corporate Nurse) stated during the course of the investigation into R2's missing [MEDICATION NAME]/[MEDICATION NAME], it was determined that over the last 90 days there was definitely a problem, as well over 1000 tablets of narcotics were unaccounted for and the police were notified. V11 also stated that diversion was likely, but they felt they did not find enough of a pattern during their investigation to say specifically who (was taking controlled substances). V11 stated the facility worked with V15 (Consultant Pharmacist) to complete their investigation. On 8/19/20 at 11:51 am, V15 (Consulting Pharmacist) stated he did not work with the facility to help determine if controlled substances were being diverted, as he is no longer assigned to that building. V15 referred to V16 (Consulting Pharmacist) as being assigned to that facility for all pharmaceutical needs. On 8/19/20 at 11:59 am, V16 stated he was unaware that the facility was missing any narcotics over the last month and nothing was reported to him as a possible/suspected diversion. V16 stated, due to the current pandemic, he is working remotely and not entering the facilities; however, the facility could have put in a special request and he would have been able to enter the facility to assist with a facility wide audit of controlled substances. V16 stated that part of his role at the Consultant Pharmacist is to assist in situations, such as this, and help identify a pattern to point to a specific staff member that could be taking the medications. On 8/18/20, V11 provided documentation related to their investigation that concluded the following: 14 additional identified residents affected (R4, R10, R14 - R25), 1283 tablets of [MEDICATION NAME]/[MEDICATION NAME], 240 tablets of [MEDICATION NAME], 60 tablets of [MEDICATION NAME], 15 tablets of Dronabinol, and 20 tablets of [MEDICATION NAME], all controlled substances, that had been determined to be suspect of diversion and missing, over the last 90 days.