STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	14E812	A. Building B. Wing	07/01/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mount Vernon Health Care Center	#5 Doctors Park Mount Vernon, IL 62864

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 - 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** 42109 Based on interview and record review, the facility failed to ensure residents were free from misappropriation of controlled substance medications for 2 of 4 residents (R1, R2,) reviewed for misappropriation in a sample of 6. This failure resulted in R2 abruptly missing 8 consecutive doses of her scheduled narcotic pain medication to which a reasonable person would experience increased pain, discomfort and possible opioid withdrawal. The findings include: A facility form titled; Fax Work Sheet Illinois Department of Public Health (IDPH) Notification Form documented in part, On 6/1/2022 (V2, Previous Director of Nursing)/Administrator) discovered that 2 pink narcotic reconciliation sheets for Hydrocodone-Acetaminophen 5-325 tabs for residents (R1) & (R2) were missing from narcotic count book. Upon further investigation the cards containing the medication associated with these pink sheets could not be located in the facility . Investigation by (V2) on 6/1/2022, (R1) & (R2) both had Norco (Hydrocodone-Acetaminophen 5-325 medications discontinued on 5/30/2022. At that time, it is believed that both residents still had medications in the cart .This nurse was unsuccessful finding the pink sheets or any empty cards . (V3 Registered Nurse-RN) phone call with (V2). (V2) asked (V3), Did you discontinue the Norco on (R1) & (R2) on 5/30/22? Answer: Yes, I did V2 asked: Did you destroy the remaining Norco that were left over? Answer: No there was no remaining Norco V2 stated, on 5/27/22 (R1) had 30 tabs of Norco delivered, (V3) stated she was unaware of that delivery. V2 explained that on 5/13/22 (R2) had 120 tabs delivered and that at the time of the discontinued order on 5/30/2022 resident should have had roughly about 52 tabs remaining. (V3) stated No, I don't think it was there. (V3) also stated I do not know what happed to it, I think they were both out .Facility is unable to fully determine what happened to missing pink narcotic sheets & medications but has enough evidence from investigation to support the theory that nurse, (V3) is culpable. Nurse has been relieved of her duties at this facility. IDFPR will be notified of findings. (continued on next page)

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.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	14E812	A. Building B. Wing	07/01/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mount Vernon Health Care Center	#5 Doctors Park Mount Vernon, IL 62864

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 - Actual harm Residents Affected - Few	On 6/28/2022 at 10:15 AM, V2 stated, she was notified by V6, Licensed Practical Nurse (LPN) on 5/31/2022 that both (R1) & (R2)'s Hydrocodone-Acetaminophen pain medication was discontinued on 5/30/2022 which was unusual due to (R1) & (R2) both took this frequently for pain. V2 stated, she called (V4) to verify the discontinue orders, and (V4) said she did not give the orders. V2 stated, upon her investigation it was found that (R1) & (R2)'s most recent Hydrocodone-Acetaminophen medication cards and associated narcotic count sheets were not found in the medication cart or logged as destroyed. V2 stated, (V3) did admit to writing both discontinuation orders but denied there was any narcotics in the medication narcotic box for either (R1) or (R2). V2 stated, (V3) was taken off the scheduled pending the investigation, and after completing the nurse interviews she found that (V3) was culpable for the misappropriation of narcotic medications. V2 stated, (V3) was unable to be reached for termination. On 6/28/2022 at 1:30 PM, V4 (Nurse Practitioner -NP) stated, she did not give (V3) orders to discontinue Hydrocodone-Acetaminophen for either (R1) or (R2) on 5/30/22. V4 also stated, (V3) called her over Memorial holiday and asked for an increase of (R2)'s Hydrocodone -Acetaminophen from 5-325mg to 7.5-325 mg because (R2) was yelling and in so much pain, and she ordered to use Tylenol as needed between doses of Norco and see how (R2) does. V4 stated, she was suspicious of (V3) calling about narcotics because she was aware of (V3) had a history of drug diversion allegations in another facility she worked at. V4 stated, the next day she received a call from (V3) telling her how well (R2) did with the Tylenol and she did not need the Norco. V4 stated after she was made aware that V3 discontinued the orders for Hydrocodone-Acetaminophen for R1 and R2 , she advised (V2) they would not reorder the hydrocodone-acetaminophen to see how both residents would do without it, and within a few days (V2) called her back and requested to restart hydrocodone-acetaminophen for both (R1) and R2) due to increased pain. V4 stated, she did not think (R1) or (R2) had any negative effects from being off the narcotic medications for the short time because they had regular Tylenol given. On 6/28/2022 at 11:15 AM, V6 Licensed Practical Nurse (LPN) stated, she found telephone orders written by (V3) to discontinue (R1) & (R2)'s hydrocodone-acetaminophen. V6 stated, she found this odd because both residents routinely took the narcotic for pain, and she reported this to (V2) immediately. V6 stated, (V2) could not find (R1) & (R2's) hydrocodone-acetaminophen medication cards, or narcotic count sheets and there was no log of destruction. V6 stated, If the narcotics were discontinued (V3) should have destroyed the narcotics and logged the destruction with another nurse as witness. V6 also stated, it is expected to document narcotics on both the narcotic control sheet and MAR's. V6 also stated, (R1) could ask for pain medication when needed, but (R2) could not ask for her pain medications so they gave (R2)'s on a routine schedule. 6/28/2022 at 2:20 PM, V8 LPN stated, she worked on 5/27/2022 and signed she received (R1)'s pharmacy delivery of Hydrocodone 7.5mg-325mg 30 pills. V8 stated, she took (R1)'s Hydrocodone 7.5mg-325mg 30 tabs to give to (V3) on the same evening and both nurses signed the associated pink narcotic count sheet. V8 LPN stated, (V3) was responsible for putting the medications in the east medication narcotic box and was the primary nurse who worked with (R1) and (R2). V8 also stated, (V2) interviewed and educated nursing to the appropriate administration, and documentation of control medication. On 6/29/2022 at 9:28 AM & 10:31 AM attempted to reach V3 by phone and was unsuccessful. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	14E812	A. Building B. Wing	07/01/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mount Vernon Health Care Center	#5 Doctors Park Mount Vernon, IL 62864

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 - Actual harm Residents Affected - Few	1. R2's Face Sheet documents, R2 was admitted to the facility on [DATE] with diagnoses in part of confusion, vascular dementia, with behavioral disturbance, hallucinations at night. R2's Physician's Order Sheet dated from 5-1-2022 to 5-31-2022 documented, Hydrocodone-Acetaminophen 5-325 mg (milligram), take one table by mouth 4 times per day at 7:00 AM, 11:00 AM, 4:00 PM, and 7:00 PM, start date of 4/15/2022. R2's POS also documented on 5/30/2022, discontinue (d/c) Norco (Hydrocodone-Acetaminophen) continue with PRN (as needed) Tylenol for pain ordered by V4 Nurse Practitioner (NP), and order signed taken by V3. This same POS also documents, Acetaminophen (Tylenol) 500 mg tablet take 2 tablets by mouth every 4 hours as needed for mild pain. R2's Medication Administration Record (MAR) sheets for 5-1-2022 to 5-31-2022 documented Hydrocodone-Acetaminophen 5-325 mg (milligram) was administered on schedule 4 times a daily at 7:00 AM, 11:00 AM, 4:00 PM, and 7:00 PM. The MAR documented on 5/30/2022 at 7:00 AM and 11:00 AM times were circled which indicated the medication was not given. The Hydrocodone-Acetaminophen was marked through as discontinued on 5/30/2022. R2's Narcotic Count Sheet and May 2022 MAR sheet had discrepancy for reconciliation of Hydrocodone-Acetaminophen 5-325 mg (milligram). The narcotic was signed given on the MAR sheet 4 times a day from 5/1/2022 to 5/29/2022, and the Narcotic Count Sheet documented narcotic was given up to 5/15/2022. The facility could not produce hydrocodone-acetaminophen narcotic count sheets for the dates of 5/16/2022 to 5/29/2022. R2's Pharmacy Delivery Sheets dated 5/13/2022 documented, R2 received an amount of 120 tablets of Hydrocodone-Acetaminophen 325 mg. R2's Narcotic Count Sheet associated with this pharmacy delivery sheet was unable to be located by the facility which leaves the 120 Hydrocodone-Acetaminophen 5-325mg unaccounted for. R2's Progress Notes dated on 5/31/2022 at 1:00 AM, and 5/31/2022 at 4:30 AM documented in part, (R2) was yelling out frequently. On 6/30/2022 at 1:37 PM, V11 (Medical Doctor -MD) stated, he was made aware of the misappropriation incident of 6/1/2022. V11 stated, he did not think abruptly stopping (R2)'s narcotic medication given 4 times a day would be harmful as long as the nursing staff closely monitored vital signs and signs and symptoms of pain. On 7/1/2022 at 11:06 AM, V2 stated, she thinks (R2) was getting regular Tylenol as needed during the time she was off the scheduled Hydrocodone Acetaminophen 5-325mg based on (R2)'s pain management flow sheets documented pain medication was given as an intervention, but they failed to document it on the PRN MAR. V2 also stated, she has since educated the nurses to document all medications administration including PRN's medications accurately to account for medication administration. R2's PRN Medication record for May 2022 does not document R2 received PRN Tylenol on either 5/30/22 or 5/31/22 for pain. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	14E812	A. Building B. Wing	07/01/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mount Vernon Health Care Center	#5 Doctors Park Mount Vernon, IL 62864

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 - Actual harm Residents Affected - Few	2. R1's Face Sheet documents R1 was admitted to facility with diagnosis of Hypertension, Depression, Acid Reflux, Hyperlipidemia, Dementia, Irritable Bowel Syndrome, Arthritis, Insomnia, Macular Degeneration, and Chronic Obstructive Pulmonary Disease. R1's Physician's Order Sheet (POS) dated 5-1-2022 to 5-31-2022 documented an order for PRN (as needed) Hydrocodone-Acetaminophen 7.5-325 mg (milligram), take one table by mouth every 6 hours as needed for pain, start date on 04/15/2022. R1's POS also documented on 5/30/2022, discontinue (d/c) Norco (Hydrocodone-Acetaminophen) continue with scheduled Tylenol ordered by (V4) and signed by (V3). R1's PRN Medication Administration Record (MAR) dated 5-1-22 to 5-31-22 documented Hydrocodone-Acetaminophen 7.5-325 mg (milligram) was administered on the following dates; 5/1/2022 at 1:30 PM, 5/7/2022 at 7:39 PM, 5/11/2022 at 4:50 AM, 5/12/2022 at 11:00 AM, 5/15/2022 at 12:30 AM, 5/16/2022 at 6:25 PM, 5/21/2022 at 2:00 PM, 5/23/2022 at 12:00 AM, 5/24/2022 at 11:45 AM, 5/25/2022 at 12:25 AM, 5/26/2022 at 2:45 AM, 5/26/2022 at 10:50 PM. R1's PRN MAR documented Hydrocodone-Acetaminophen 7.5-325 mg was discontinued on 5/30/2022. R1's Narcotic Count Sheet with a delivery date of 4/25/2022, documented an amount of 30 Hydrocodone-Acetaminophen 7.5-325 mg tabs. The same narcotic count sheet documented in part, the narcotic was administered on 5/1/2022 at 0700 AM, 5/1/2022 at 1230 PM, 5/1/2022 at 6:00 PM, 5/2/2022 at 7:00 AM, 5/2/2022 at 2:30 PM, 5/2/2022 at 7:40 PM, 5/3/2022 at 7:00 AM, 5/3/2022 at 12:00 PM, 5/3/2022 at 6:00 PM, 5/4/2022 at 7:00 AM, 5/5/2022 at 6:30 AM, 5/5/2022 at 11:45 AM, 5/5/2022 at 5:15 PM, and 5/5/2022 at 11:00 PM. The same Narcotic Count Sheet and May 2022 MAR sheet had discrepancy for reconciliation of narcotic administration for the dates of 5/7/2022, 5/11/2022, 5/12/2022, 5/15/22, 5/16/22, 5/21/2022, 5/23/2022, 5/24/2022, and 5/25/2022. The facility was unable to produce R1's narcotic count sheets for Hydrocodone-Acetaminophen 7.5mg-325 mg administered from dates 5/7/2022 to 5/25/2022. R1's undated Narcotic Count Sheet, documented, Hydrocodone-Acetaminophen 7.5-325 mg every 6 hours as needed, an amount of 4 tabs documented, Hydrocodone-Acetaminophen 7.5-325 mg was administered on 5/26/2022 at 2:45 AM, 5/26/2022 at 9:00 AM, 5/26/2022 at 2:30 PM, and 5/26/2022 at 10:50 PM. The same Narcotic Count Sheet and May 2022 MAR sheet had discrepancy for reconciliation of narcotic administration for the dates for 5/26/2022 at 9:00 AM, and 5/26/2022 at 2:30 PM. A Pharmacy delivery sheet dated 5/27/2022 documented, R1 received 30 Hydrocodone-Acetaminophen 7. 5-325 mg tablets. R1's Narcotic Count Sheet associated with this pharmacy delivery were unable to be located by the facility which leaves 30 Hydrocodone-Acetaminophen 7.5 mg-325 mg tablets unaccounted for. A facility policy titled, Abuse Prevention Program, dated revised on 11/28/2216 documents the following in part - Policy, This facility affirms the right of our residents to be free from abuse, neglect, misappropriation of resident property .The Purpose of this policy is to ensure that the facility is doing all that is within its control to prevent occurrences of mistreatment, exploitation, neglect or abuse of our residents .Definitions: Misappropriation of resident property means the deliberate misplacement, exploitation, or wrongful, temporary, or permanent use of resident's belonging or money without the resident's consent. Facility Policy entitled, Medication Administration date revised on 11/18/2017, documented in part, 19. Document any medications not administered for any reason by circling initials and documenting on the back of the MAR the date, the time, the medication and dosage, reason for omission and initials. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	14E812	A. Building B. Wing	07/01/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mount Vernon Health Care Center	#5 Doctors Park Mount Vernon, IL 62864

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 - Actual harm Residents Affected - Few	The Center for Disease (CDC) Guide for Clinicians on the Appropriate Dosage Reduction or Discontinuation of Long-Term Opioid Analgesics, dated October 2019, documented in part, This HHS Guide for Clinicians on the Appropriate Dosage Reduction or Discontinuation of Long-Term Opioid Analgesics provides advice to clinicians who are contemplating or initiating a reduction in opioid dosage or discontinuation of long-term opioid therapy for chronic pain. In each case the clinician should review the risks and benefits of the current therapy with the patient and decide if tapering is appropriate based on individual circumstances.Risks of rapid opioid taper 1. Opioids should not be tapered rapidly or discontinued suddenly due to the risks of significant opioid withdrawal .

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	14E812	A. Building B. Wing	07/01/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mount Vernon Health Care Center	#5 Doctors Park Mount Vernon, IL 62864

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 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** 42109 Based on interview and record review the facility failed to document and reconcile resident medications on the MAR (Medication Administration Record) and Control Substance Proof of Use Sheet (Narcotic Count Sheet) for 2 of 4 residents (R1, R2) reviewed for controlled substance medication administration in a sample of 6. Noncompliance occurred from 5/1/2022 to 6/1/2022. The findings include: 1. R2's Face Sheet documents, R2 was admitted to the facility on [DATE] with diagnoses in part of confusion, vascular dementia, with behavioral disturbance, hallucinations at night. R2's Physician's Order Sheet (POS)dated from 5-1-2022 to 5-31-2022 documented, Hydrocodone-Acetaminophen 5-325 mg (milligram), take one table by mouth 4 times per day at 7:00 AM, 11:00 AM, 4:00 PM, and 7:00 PM, start date of 4/15/2022. R2's POS also documented on 5/30/2022, discontinue (d/c) Norco (Hydrocodone-Acetaminophen) continue with PRN (as needed) Tylenol for pain ordered by V4 Nurse Practitioner (NP), and order signed taken by V3. R2's Medication Administration Record (MAR) sheets for 5-1-2022 to 5-31-2022 documented Hydrocodone-Acetaminophen 5-325 mg (milligram) was administered on schedule 4 times a day at 7:00 AM, 11:00 AM, 4:00 PM, and 7:00 PM. The MAR documented on 5/30/2022 at 7:00 AM and 11:00 AM times were circled which indicated the medication was not given. The Hydrocodone-Acetaminophen was marked through as discontinued on 5/30/2022. R2's Narcotic Count Sheet and May 2022 MAR sheet had discrepancy for reconciliation of Hydrocodone-Acetaminophen 5-325 mg (milligram). The narcotic was signed given on the MAR sheet 4 times a day from 5/1/2022 to 5/29/2022, and the Narcotic Count Sheet documented narcotic was given up to 5/15/2022. The facility could not produce hydrocodone-acetaminophen narcotic count sheets for the dates of 5/16/2022 to 5/29/2022. R2's Pharmacy Delivery Sheets dated 5/13/2022 documented, R2 received an amount of 120 tablets of Hydrocodone-Acetaminophen 325 mg. R2's Narcotic Count Sheet associated with this pharmacy delivery sheet was unable to be located by the facility which leaves the 120 Hydrocodone-Acetaminophen 5-325mg unaccounted for. 2. R1's Face Sheet documents R1 was admitted to facility with diagnosis of Hypertension, Depression, Acid Reflux, Hyperlipidemia, Dementia, Irritable Bowel Syndrome, Arthritis, Insomnia, Macular Degeneration, and Chronic Obstructive Pulmonary Disease. R1's Physician's Order Sheet (POS) dated 5-1-2022 to 5-31-2022 documented an order for PRN (as needed) Hydrocodone-Acetaminophen 7.5-325 mg (milligram), take one table by mouth every 6 hours as needed for pain, start date on 04/15/2022. R1's POS also documented on 5/30/2022, discontinue (d/c) Norco (Hydrocodone-Acetaminophen) continue with scheduled Tylenol ordered by (V4) and signed by (V3). (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	14E812	A. Building B. Wing	07/01/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mount Vernon Health Care Center	#5 Doctors Park Mount Vernon, IL 62864

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 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R1's PRN Medication Administration Record (MAR) dated 5-1-22 to 5-31-22 documented Hydrocodone-Acetaminophen 7.5-325 mg (milligram) was administered on the following dates; 5/1/2022 at 1:30 PM, 5/7/2022 at 7:39 PM, 5/11/2022 at 4:50 AM, 5/12/2022 at 11:00 AM, 5/15/2022 at 12:30 AM, 5/16/2022 at 6:25 PM, 5/21/2022 at 2:00 PM, 5/23/2022 at 12:00 AM, 5/24/2022 at 11:45 AM, 5/25/2022 at 12:25 AM, 5/26/2022 at 2:45 AM, 5/26/2022 at 10:50 PM. R1's PRN MAR documented Hydrocodone-Acetaminophen 7.5-325 mg was discontinued on 5/30/2022. R1's Narcotic Count Sheet with a delivery date of 4/25/2022, documented an amount of 30 Hydrocodone-Acetaminophen 7.5-325 mg tabs. The same narcotic count sheet documented in part, the narcotic was administered on 5/1/2022 at 07:00 AM, 5/1/2022 at 12:30 PM, 5/1/2022 at 6:00 PM, 5/2/2022 at 7:00 AM, 5/2/2022 at 2:30 PM, 5/2/2022 at 7:40 PM, 5/3/2022 at 7:00 AM, 5/3/2022 at 12:00 PM, 5/3/2022 at 6:00 PM, 5/4/2022 at 7:00 AM, 5/5/2022 at 6:30 AM, 5/5/2022 at 11:45 AM, 5/5/2022 at 5:15 PM, and 5/5/2022 at 11:00 PM. The same Narcotic Count Sheet and May 2022 MAR sheet had discrepancy for reconciliation of narcotic administration for the dates of 5/7/2022, 5/11/2022, 5/12/2022, 5/15/22, 5/16/22, 5/21/2022, 5/23/2022, 5/24/2022, and 5/25/2022. The facility was unable to produce R1's narcotic count sheets for Hydrocodone-Acetaminophen 7.5mg-325 mg administered from dates 5/7/2022 to 5/25/2022. R1's undated Narcotic Count Sheet, documented, Hydrocodone-Acetaminophen 7.5-325 mg every 6 hours as needed, an amount of 4 tabs documented, Hydrocodone-Acetaminophen 7.5-325 mg was administered on 5/26/2022 at 2:45 AM, 5/26/2022 at 9:00 AM, 5/26/2022 at 2:30 PM, and 5/26/2022 at 10:50 PM. The same Narcotic Count Sheet and May 2022 MAR sheet had discrepancy for reconciliation of narcotic administration for the dates for 5/26/2022 at 9:00 AM, and 5/26/2022 at 2:30 PM. A Pharmacy delivery sheet dated 5/27/2022 documented, R1 received 30 Hydrocodone-Acetaminophen 7.5-325 mg tablets. R1's Narcotic Count Sheet associated with this pharmacy delivery was unable to be located by the facility which leaves 30 Hydrocodone-Acetaminophen 7.5 mg-325 mg tablets unaccounted for. On 6/28/2022 at 1:30 PM, V4 (Nurse Practitioner- NP) stated, she did not give (V3-Registered Nurse-RN) orders to discontinue Hydrocodone-Acetaminophen for either (R1) or (R2) on 5/30/22. On 6/28/2022 at 11:15 AM, V6 Licensed Practical Nurse (LPN) stated, it is expected to document narcotics on both the narcotic control sheet and MAR's. On 6/28/2022 at 2:20 PM, V8 LPN stated, she worked on 5/27/2022 and signed she received (R1)'s pharmacy delivery of Hydrocodone 7.5mg-325mg 30 pills. V8 stated, she took (R1)'s Hydrocodone 7.5mg-325mg 30 tabs to give to (V3) on the same evening and both nurses signed the associated pink narcotic count sheet. V8 stated, (V3) was responsible for putting the medication in the east medication narcotic box and was the primary nurse who worked with (R1) and (R2). V8 also stated, (V2) interviewed and educated nursing to the appropriate administration, and documentation of control medication. On 6/29/2022 at 8:48 AM, V10 LPN stated, when administering pain medication, they document pain level on a pain management flow sheet, document medication administration on the MAR, and if it is a controlled substance the medication is signed out and documented on the narcotic count sheet as well. On 7/1/2022 at 11:06 AM, V2 ((Previous DON)/Administrator), stated, she has educated the nurses to document all medications administration including PRN's medications accurately to account for medication administration. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	14E812	A. Building B. Wing	07/01/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mount Vernon Health Care Center	#5 Doctors Park Mount Vernon, IL 62864

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 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Facility Policy entitled, Medication Administration date revised on 11/18/2017, documented in part, .16. After a drug is given, record the date, time, name of drug, dose and route on the resident's individual Medication Administration Record. 17. If a prn is administered, document on the PRN sheet the date, the time, medication and dosage, reason for administration and initials. Give prns for indications listed with attention to the parameters listed. Return to chart results as appropriate on the PRN sheet. PRN Pain mediation may be documented on the Pain Management Flow Record . 19.Document any medications not administered for any reason by circling initials and documenting on the back of the MAR the date, the time, the medication and dosage, reason for omission and initials. Prior to the survey date, the facility took the following actions to correct the noncompliance: A facility form titled; Fax Work Sheet Illinois Department of Public Health (IDPH) Notification Form, Dated on 6/1/2022 documented in part by (V2), This writer went through the narcotic count book and all narcotics to assure that current medications were accounted for. All current medications and pink sheets are in place and accounted for on this date 6/1/2022. Interventions in place, educated all nursing staff on how controlled medications are to be destroyed. 2 nurses are to sign off and witness the destruction of the narcotic medication, once both nurses have witnessed the destruction of the narcotic medication, once both nurses have witnessed and signed the pink medication sheet, the pink medication sheet is to be turned in to the Director of Nursing. Pharmacy destruction log is also to be filled out showing the medication was destroyed, Interventions in place, when blue pharmacy sheet comes from pharmacy indicating that the medication is controlled narcotic 2 nurses (if applicable) are to sign showing that they both witnessed the medication being delivered to the facility, and 2 nurses are also at that time to sign the pink narcotic count sheet stating how much of the medication was delivered. All nursing staff have been educated/in-service on this protocol. On 6/28/2022 at 11:00 AM and 6/29/2022 8:00 AM Completed Medication Pass Observation. Narcotic Count Sheets were correct with no medication errors. V5 Registered Nurse (RN) and V6 Licensed Practical Nurse (LPN) both stated after the 6/1/2022 Medication Misappropriation incident, (V2) educated nursing about controlled substance administration, documentation. V2 instituted a Narcotic Tracking Sheet which is placed in the narcotic count book for 2 nurses to count the number of cards/boxes before reconciling each card with the pink narcotic count sheets. An untitled facility document found in each Narcotic Count Book documented, The Date, number of cards, number of boxes added or subtracted to the narcotic box, A reason box, incoming nurse signature, and outgoing nurse signature. On 6/28/2022 at 11:00 AM, V5 RN stated she was educated by (V2) regarding protocol for controlled substance and new tracking form. Stated she documents controlled substance medications on narcotic sheet and MAR's. On 6/28/2022 at 11:15 AM, V6 LPN stated she was also educated by (V2) regarding control substance protocol and tracking form. Stated she documents controlled substances on narcotic sheets and MAR. On 6/28/2022 at 2:20 PM, V8 LPN stated she was educated to controlled substance policy and tracking form after 6/1/2022 by (V2). V8 stated she documents controlled substance medications on narcotic sheet and MAR's. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	14E812	A. Building B. Wing	07/01/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mount Vernon Health Care Center	#5 Doctors Park Mount Vernon, IL 62864

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 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 6/29/2022 at 8:50 AM, V10 LPN stated, she received education regarding the controlled substance and medication administration after the 6/1/2022 incident. V10 also stated, she documents narcotics on both the MAR and the Narcotic Sheets. On 6/30/2022 at 1:37 PM, V11 Medical Director (MD) stated he was called by (V2) and (V4) regarding the 6/1/2022 medication misappropriation incident and they discussed the interventions put in place. R2's June 2022 Physician Orders and MAR documented Hydrocodone-Acetaminophen 5-325mg po every 6 hours. R2's Narcotic Count Sheet dated on 6/8/2022 1 of 4 and 2 of 4 both reconciled with MAR. R1's June 2022 Physician Orders and MAR documented Hydrocodone-Acetaminophen 7.5mg-325mg po every 6 hours prn. R1's Narcotic Count Sheet dated on 6/6/2022 reconciled with the PRN MAR.